

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

Reg. Dist. No. 10600 40

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred:
734 N. Mechanic St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 734 N. Mechanic St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

William Edward Arnold

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Elizabeth Keightum

7. Birth date of deceased (mo., day, yr.) April 1, 1861 6.(c) If alive, give age..... years

8. AGE: Years 85 Months 7 Days 9 If less than one day..... hrs. min.

9. Birthplace Ind. Savage Ind.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Jessie Arnold

13. Birthplace Ind.

14. Maiden name Bridget Caroline

15. Birthplace Ind.

16. Informant Rose Mary Lindner

Address Cumberland

17. Burial, cremation, or removal Which? Burial Date thereof Nov 12 46
(month) (day) (year)

Cemetery or crematory St. Patrick's Cem

Location Cumberland

18. Funeral director Amig. Stein Inc

Address Cumberland

19. Nov. 11, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 19 46, at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/17/46 19 46 to 11/10 19 46

and that I last saw him alive on 11/1/46 19 46

Immediate cause of death Cardiac arrest

DURATION

Due to arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE OK M. D. or other

Address 122/100th St Date signed 11/11/46

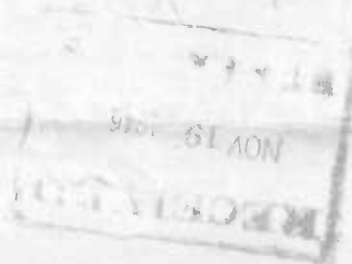
MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-31



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10691

1. PLACE OF DEATH:

County.....Charles
 City or town.....Lanacoring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....40 years
 Hospital, institution, or street address where death occurred:
76 Douglas Avenue
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....Maryland County.....Allegany
 City or town.....Lanacoring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 76 Douglas Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Charles Barclay

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Bessie Reives

7. Birth date of deceased (mo., day, yr.) October 13, 1878

8. AGE: Years 68 Months 1 Days 5 If less than one day hrs. min.

9. Birthplace Lanacoring, Allegany Co., Md.
 (Town, county, and state)

10. Usual occupation Coal Miner (Retired)

11. Industry or business Detroit Mine

12. Name Robert Barclay

13. Birthplace Scotland

14. Maiden name Mary Frazier

15. Birthplace Scotland

16. Informant Wilson Reives

Address Lanacoring, Md.

17. Burial Date thereof Nov 21, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lanacoring, Md.

18. Funeral director M. Eichhorn

Address Lanacoring, Md.

19. Nov 20 19 46 Jannette M. Bell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov. 18 19 46 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him alive on Sept. 15 19 46

Immediate cause of death.....

Distention of heart

Due to.....

Chronic Bronchial Asthma

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Henry M. Hodges M. D. or other

Address.....

Lanacoring, Md. Date signed Nov 20 46

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JAN 23 1946
BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10602

40

1. PLACE OF DEATH:

County... Allegany County
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 H.R.
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 11 Hrs. and 35 Min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... West Virginia County... MORGAN
City or town... Paw Paw
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION) (5)
2.(a) If veteran, name war... WORLD WAR I

3. (a) FULL NAME

Constantine Bevans

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife... Ruth WENTLING

7. Birth date of deceased (mo., day, yr.) June 15, 1893 8. (c) If alive, give age _____ years

8. AGE: Years 53 Months 4 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace... West Virginia
(Town, county, and state)

10. Usual occupation... MERCHANT

11. Industry or business

FATHER 12. Name... DANIEL BEVANS

13. Birthplace... W. VA.

MOTHER 14. Maiden name... BRIDGET McCORMICK

15. Birthplace... W. VA.

18. Informant... MRS. C. W. BEVANS

Address... PAW PAW W. VA.

17. BURIAL Date thereof NOV. 4, '46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... ST. MARYS BURIAL PARK

Location... RURAL CUMBERLAND M.D.

18. Funeral director... LOUIS STEIN INC.

Address... CUMBERLAND M.D.

19. Nov. 3, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... November 2, 1946 at 2:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 - 1 19 46 11 - 2 19 46
and that I last saw him/her alive on 11 - 1 19 46

Immediate cause of death... Myocarditis

Due to... Not known

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... J. P. Franklin, M.D.

Address... Cumberland W. Va. Date signed... 11-3-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

10-15-46

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FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
OCT 13 1946

BUREAU V.

2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10603

90

1. PLACE OF DEATH:

County Allegany
 City or town Eckhart
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Eckhart
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Bollinger

3. (b) Social Security Number

214-01-6688

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Elizabeth Bollinger6. (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.)

May 13, 1900

8. AGE:

Years

46

Months

5

Days

20

If less than one day

hrs.

min.

9. Birthplace

Eckhart, Allegany, Maryland
(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

Celanese Corporation

FATHER

12. Name

George Bollinger.

13. Birthplace

France

MOTHER

14. Maiden name

Anna M. Felklin.

15. Birthplace

Switzerland

16. Informant

Mrs. George Bollinger.

Address

Eckhart, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 5, 1946
(month) (day) (year)

Cemetery or crematory

Allegany

Location

Frostburg, Md.

18. Funeral director

J. J. Durst.

Address

Frostburg, Md.

19.

11-5

(Date rec'd by registrar)

19.

46Mrs. Nancy A. De
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 219 46 11.20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 46 to 19 46
 and that I last saw him Dead Nov. 2

Immediate cause of death

DURATION

Chronic Endocarditis about 5 yrs.

Due to

arthritisabout 6 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Mechanism of injury

Injured at work?

23. SIGNATURE

H.V. Deming M.D.

M. D. or other

Address

Cumberland Md

Date signed

11/3/46

Deputy Medical Examiner - Allegany Co.

RECEIVED
NOV 7 1946
BUREAU V.E.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 70-2

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 hours
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Midland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Paradise Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Richard Brinegar

3. (b) Social Security Number

218-24-9563

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov 11, 1929 6. (c) If alive, give age 1 years

8. AGE: Years 17 Months - Days 1 If less than one day

hrs. min.

9. Birthplace Midland, Allegany Co., Md.
 (Town, county, and state)

10. Usual occupation Barber/Worker

11. Industry or business Helley-Springfield Tire Co.

12. Name Thomas Earl Brinegar

13. Birthplace Parkersburg, W. Va.

14. Maiden name Catherine Harmoness Smith

15. Birthplace Cumberland, Md.

16. Informant Mrs. Catherine Brinegar

Address Midland, Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Nov. 15, 1946
 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director J. P. Eichhorn

Address Lonaconing, Md.

19. 11-15 19 46 Nov 15 1946
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 19 46 at 10:52 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him dead Nov 12

Immediate cause of death Pulmonary hemorrhage

Due to fractured ribs

Automobile accident while driving too fast; failed to make a curve.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

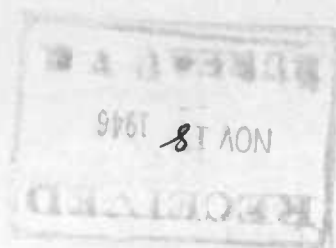
Injured at home, farm, industry, public place, (where?)

Means of injury Auto accident Injured at work?

23. SIGNATURE H. V. Downing M.D. M. D. or other

Address Cumberland, Md. Date signed 11/13/46

Deputy Medical Examiner - Allegany Co.



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Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

10605

Reg. Diat. No. 40

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47 mo
Hospital, institution, or street address where death occurred:
501 Oldtown Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 501 Oldtown Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mary Julia Brinker

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Fredrick L. Brinker
6.(c) If alive, give age... years
7. Birth date of deceased (mo., day, yr.) April 8 1898

8. AGE: Years 48 Months 7 Days 22 It less than one day hrs. min.

9. Birthplace Cumberland Ind.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at home

12. Name Frank Schultz

13. Birthplace Germany

14. Maiden name Bertha Holterman

15. Birthplace Germany

16. Informant Fredrick L. Brinker

Address Cumberland

17. Burial Date thereof Dec 3 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Peter & Pauls Ch.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Nov 30 19 46 Joseph D. Brinker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 19 46, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19 to November 29 19 46 and that I last saw him alive on November 29 19 46

Immediate cause of death Carcinoma of breast DURATION 1 yrs 10 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. Johnson Nov 27
Address Cumberland, Md. Date signed 11-30-46

MARGIN RESERVED FOR BINDING

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VS-A15 9.45.15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 3 1946

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10606

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

209 Grand Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 209 Grand Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Laura V. Carroll

3. (b) Social Security Number

705-12-4609

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

F

W

Widowed

6. (b) Name of husband or wife Robt. W. Carroll7. Birth date of deceased (mo., day, yr.) April 13, 1864
6. (c) If alive, give age..... years8. AGE: Years Months Days If less than one day
82 6 25 hrs. min.9. Birthplace West Va.
(Town, county, and state)10. Usual occupation Matron (B&O Station)

11. Industry or business

12. Name Will T. Kelley13. Birthplace West Va.14. Maiden name Hulda Sisler15. Birthplace West Va.16. Informant A. W. CarrollAddress 304 Arch St.17. Burial Date thereof Nov. 10, 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill Cem.Location Cumberland, Md.18. Funeral director Louis Stein Inc.Address Cumberland Md.19. Nov. 9, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1946 at21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 46 to Nov. 8, 1946and that I last saw him alive on Nov. 7, 1946Immediate cause of death CarcinomatousDue to Carcinoma of Rectum 2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Rectum
Date of op. June 1944

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE ccoy James
M. D. or otherAddress Cumberland Date signed 11-8-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 13 1946
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10687

1. PLACE OF DEATH:

County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 hours
 Hospital, institution, or street address where death occurred:
Barnes Hospital
 How long in hospital or institution? 24 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. P.O. #2 Box 313
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Harvey H. Caton

3. (b) Social Security Number

213-05-7079

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Sarah Brown

7. Birth date of deceased (mo., day, yr.) July 10 - 1892 6.(c) If alive, give age 56 years

8. AGE: Years 54 Months 4 Days 4 If less than one day
 hrs. min.

9. Birthplace Frederick County
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Clay Miner

12. Name Charles Caton

13. Birthplace Frederick Co

14. Maiden name Barbara Yashty

15. Birthplace Frederick Township

16. Informant Mrs. Harvey H. Caton

Address P.O. #2 Box 313 Frederick Md

17. Burial, cremation, or removal-Which? Burial Date thereof 11-17-1948
 (month) (day) (year)

Cemetery or crematory Frederick Cemetery

Location Frederick Md

18. Funeral director Joseph Orger

Address Frederick Md

19. 11-16 1946 Mrs. Harvey H. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1946, at 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to Nov 14 1946
 and that I last saw him alive on Nov 13 1946

Immediate cause of death Exhaustion of Heart

Failure

Due to Sclerosis

Due to Arteriosclerosis

Arteriosclerosis

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations Arteriosclerosis

Date of op. Nov 14

Autopsy results Arteriosclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Arteriosclerosis Date of Nov 14

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Allen G. Murawski
 M. D. or other

Address Frederick Md Date signed Nov 14 1946

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1-31-
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NOV 19 1948
BUREAU

CERTIFICATE OF DEATH

★ 10608
40
Reg. Dist. No.

1. PLACE OF DEATH ALLEGANY

County..... CUMBERLAND, MD.
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... MARYLAND County..... GARRETT
City or town..... SHALTMAR
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MR. STEVE ~~COMA~~ Choma

3. (b) Social Security Number

236-12-0297

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED

6.(b) Name of husband or wife..... ANNA Margae

7. Birth date of deceased (mo., day, yr.)..... Unknown 6.(c) If alive, give age..... years

8. AGE: Years 66 Months ? Days ? If less than one day..... hrs. min.

9. Birthplace..... RUSSIA (Town, county, and state) WOLETON MINING CO.

10. Usual occupation.....

11. Industry or business

12. Name..... PETE Choma 13. Birthplace..... Austria

14. Maiden name..... ANNA Unknown

15. Birthplace.....

16. Informant..... O. F. Sharpless

Address..... Blaine, W. Va.

17. Burial Date thereof..... 11/30/46 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Kalbaugh Cemetery

Location..... Elk Garden, W. Va.

18. Funeral director..... O. F. Sharpless

Address..... Blaine, W. Va.

19. Nov. 29 19. 46 J. P. Franklin, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

NOVEMBER 28, 1946 12:05 A.M.

20. DATE OF DEATH..... 19. at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 8 19. 46 to Nov 25 19. 46

and that I last saw him alive on 11/27/46 19.

Immediate cause of death..... Carcinoma stomach

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... J. P. Franklin, M.D. M. D. or other

Address..... Cumberland Md. Date signed..... 11/28/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 3 1946

BUREAU V 8

1-35

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10669

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State PENNA. County FAYETTE
City or town OHIO PYLE
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME DAVID L. COLLINS
3. (b) Social Security Number None

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife MARY STAUP

7. Birth date of deceased (mo., day, yr.) MAY 20, 1884 6.(c) If alive, give age _____ years

8. AGE: Years 62 Months 5 Days 15 It less than one day _____ hrs. _____ min.

9. Birthplace PENNA. (Town, county, and state)

10. Usual occupation NONE - Retired

11. Industry or business Stone mason

12. Name ISAIAH COLLINS

13. Birthplace PENNA.

14. Maiden name LYDIA BOYD

15. Birthplace PENNA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Nov. 8, 1946 (month) (day) (year)

Cemetery or crematory Ohio Pyle Cem.

Location Ohio Pyle, Penna.

18. Funeral director Kumbeck Funeral Home

Address Confluence, Penna.

19. Nov. 6, 1946 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 5, 1946 at 7:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOV. 3, 1946 to NOV. 5, 1946

and that I last saw him alive on NOV. 5, 1946

Immediate cause of death myocardial degeneration
arteriosclerosis

Due to _____

Due to _____

Other conditions chronic nephritis with
hypertension
(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Howard D. Tolson, M.D. M. D. or other _____

Address Cumberland, Md. Date signed 11-5-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 13 1946

BUREAU OF

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-5

10610

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
515 Fort Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 515 Fort Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

Lawson C. Collins

3.(b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(c) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Francis Garland Collins

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1867
 8. AGE: Years 78 Months 10 Days 23 If less than one day hrs. min.

9. Birthplace Artemas, Pa.
 (Town, county, and state)

10. Usual occupation Retired11. Industry or business Farmer12. Name Wesley Collins13. Birthplace Penna.14. Maiden name Amanda Toole15. Birthplace Penna.16. Informant McCormick CollinsAddress 158 Polk St. Cumberland, Md.

17. Burial Date thereof Nov. 17, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Hope Cem.Location Near Artemas, Pa.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.

19. Nov. 17, 1946 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1946 at 7:43 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 27 H. 1946 to Nov. 14 H. 1946
 and that I last saw him alive on Nov. 14 H. 1946

Immediate cause of death Gastric carcinoma. DURATION ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James E. H. Lian M.D.

Address 49 Green St. Date signed 11-15-46
 M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The color age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 26 1946

ST. LOUIS 13

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

CERTIFICATE OF DEATH

10611

Reg. Dist. No.

40

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

708 Yale St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 708 Yale St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Monroe J. Conrad

3. (b) Social Security Number

705-05-5200

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Laura Grace Hinds6. (c) If alive, give age 50 years7. Birth date of
deceased (mo., day, yr.) September 5, 1892

8. AGE:

Years

Months

Days

If less than one day

54126

hrs.

min.

9. Birthplace Lucretia, Virginia
(Town, county, and state)10. Usual occupation Car repairman11. Industry or business BOO T. R.12. Name David Conrad13. Birthplace Richmond, Va.14. Maiden name Anna Galatt15. Birthplace Virginia16. Informant Mrs. Laura G. ConradAddress 708 Yale St.17. Burial Date thereof November 4, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peter & Paul's CemeteryLocation Cumberland, Md.19. Funeral director John G. H. H.Address Cumberland, Md.19. Nov. 3 19 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 19 46 at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19 45 to Nov 1 19 46
and that I last saw him alive on Oct 31, 1946

Immediate cause of death

Scirrhous Carcinoma
Stomach

DURATION

5 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Scirrhous Carcinoma
StomachDate of op. July 26, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE

John A. Topper MD
Physician

M. D. or other

Address Cumberland, Md. Date signed 11.2.46

RECEIVED
NOV 13 1946
BUREAU V.R.
2-35

RECEIVED
NOV 13 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24-0)

CERTIFICATE OF DEATH

Reg. Dist. No. 10012 7

DR. WHITWORTH

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 19 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 317 MARYLAND AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

MRS. MAYME COZAD

3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife SAMUEL COZAD

6. (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) MAY 8, 1894

8. AGE: Years 52 Months 6 Days 9 It less than one day hrs. min.

9. Birthplace PENNSYLVANIA
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name JOHN SMITH

13. Birthplace WEST VIRGINIA Pa

14. Maiden name MARY, BANKER

15. Birthplace PENNSYLVANIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial Date thereof Nov. 19, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hill Crest Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. Nov. 18, 1946 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 17, 1946 at 12:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death Fatty Degeneration of Liver.

Due to Alcoholism Chronic

Due to

Other conditions Icterus severe

(Include pregnancy within 3 months of death)

Major findings of operations Hepatomegaly with complete fatty degeneration, Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Guller B Whitworth M. D. or other

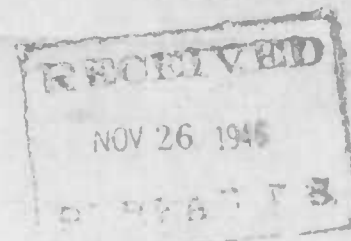
Address 112 Bedford St. Date signed 19 Nov 46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 100139

1. PLACE OF DEATH:

County Allegany
 City or town Protestburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Miners' Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Protestburg-R.F.D. - 1 Box
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Wrights Crossing
 (If rural, give LOCATION)
 2.(a) If veteran, name war not

3. (a) FULL NAME

George Davis

3. (b) Social Security Number

220-10-0977

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mary Jones
 7. Birth date of deceased (mo., day, year) Mar 21, 1863 8.(c) If alive, give age 82 years

8. AGE: Years 83 Months 7 Days 24 If less than one day
 hrs. min.

9. Birthplace Irwin Scotland
 (Town, county, and state)

10. Usual occupation Coal Miner Retired

11. Industry or business Jenkins Coal Co.

12. Name William Davis

13. Birthplace Irwin, Scotland

14. Maiden name Mary Anne

15. Birthplace Irwin, Scotland

16. Informant Mrs. Mary Neat

Address Protestburg, Md. R.F.D. - 1 Box 8

17. Burial Date thereof Nov. 17, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Protestburg, Md.

18. Funeral director Mr. Eichhorn

Address Lonaconing, Md.

19. 11-87 1946 Mr. Stanley H. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 19 46, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 13 19 46, to Nov 13 19 46.

and that I last saw him alive on Nov 14 19 46.

Immediate cause of death Cerebral Hemorrhage DURATION 2 Day

RT Hemiplegia

Due to Arteriosclerosis years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. Lane Jr. M.D. M. D. or other

Address Protestburg, Md. Date signed 11-16-46

1-35
RECEIVED
NOV 19 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10614

Reg. Dist. No. 60

1. PLACE OF DEATH:

County Allegany
City or town Barton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Barton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war.

3. (a) FULL NAME

John Edward Deniker

3. (b) Social Security Number

216-05-2937

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Mary Mowbray Deniker 6. (c) If alive, give age 32 years
7. Birth date of deceased (mo., day, yr.) XXXXXXX April 4, 1910
8. AGE: Years 36 Months 7 Days 20 If less than one day
hrs. min.

9. Birthplace Meyersdale-Somerset-Penna.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business W. Va. Pulp and Paper Co
12. Name William E. Deniker
13. Birthplace Pennsylvania
14. Maiden name Arla Bowser
15. Birthplace Pennsylvania

16. Informant Mrs Mary Mowbray Deniker
Address Barton, Maryland
17. Burial Date thereof 26 Nov 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Laurel Hill Cemetery
Location Moscow, Maryland

18. Funeral director Ellsworth S. Roal
Address 111 Church St, Westernport, Md
19. Nov. 26 1946
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1946, at A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 to 19
and that I last saw him in Bed Nov 24 1946

Immediate cause of death Coronary occlusion DURATION at one

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE H. V. Denning M.D. M. D. or other
Address Cumberland Md Date signed 11/24/46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 29 1946
BUREAU
1-35

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

10615



40

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 Months
Hospital, institution, or street address where death occurred:
Rt # 1.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt # 1.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Hannah Dever

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Aaron Dever

6. (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) October 26 1880

8. AGE: Years 66 Months 0 Days 10 If less than one day hrs. min.

9. Birthplace Pennelton Co., West Virginia
(Town, county, and state)

10. Usual occupation House Duty

11. Industry or business Own House

12. Name Samuel L. Kimble

13. Birthplace Pennelton Co., W. Va.

14. Maiden name Elizabeth Westfall

15. Birthplace Pennelton Co., W. Va.

16. Informant Lester Dever

Address R.F.D # 3, Keyser, W. Va.

17. Burial Date thereof 11/9/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Nov. 8 19 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 19 46 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 5 19 46 to Nov 4 19 46
and that I last saw her alive on Nov 19 46

Immediate cause of death Pulmonary Tuberculosis

Due to Cardio Renal

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. Barclay Hunter M.D. M. D. or other

Address Cumberland, Md. Date signed 11/6/46

MARGIN RESERVED FOR BINDING

I

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 13 1945
BUREAU

1-35

Within corporate limits

R. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9320

CERTIFICATE OF DEATH

10616

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegheny

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 YRS

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 35 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 748 Washington Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Albert Doub

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife Anna Cochran Doub

7. Birth date of deceased (mo., day, yr.) April 11, 1865

6.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
81 7 3hrs.min.

9. Birthplace Maryland
(town, county, and state)

10. Usual occupation Retired Judge

11. Industry or business

12. Name Doub, Phillip

13. Birthplace Maryland

14. Maiden name Shutmer, Cornelia

15. Birthplace Maryland

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial Date thereof Nov. 15, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. Nov 15 19 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 19 46, at 3:05p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 19 46 to Nov 14 19 46 and that I last saw him alive on Nov 14 19 46

Immediate cause of death Chronic Myocarditis
& infarction of age
Arteriosclerosis
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?

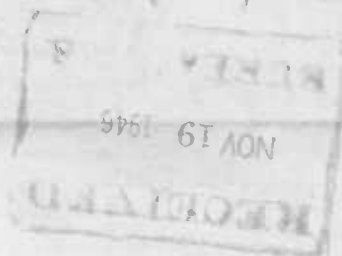
23. SIGNATURE R. Williams M.D.
Address Cumberland, Md. Date signed 11/14/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Elizabeth Bragg

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

CERTIFICATE OF DEATH



10617

Reg. Dist. No.

40

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 78 years

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 450 N. Centre St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Anna Elizabeth Dreyer

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife John G. Dreyer6. (c) If alive, give age 82 years7. Birth date of deceased (mo., day, yr.) January 25, 18688. AGE: Years 78 Months 9 Days 12 If less than one day
..... hrs. min.9. Birthplace Cumberland, Allegheny, MD
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name Nicholas Sebade13. Birthplace Germany14. Maiden name Martha Winthrop15. Birthplace Germany16. Informant Mrs. C.W. FullerAddress Cumberland, MD.17. Burial Date thereof November 9, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greenmount CemeteryLocation Cumberland, MD.18. Funeral director John J. HoferAddress Cumberland, Md.19. Nov. 8, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7, 1946 at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1944 to Nov. 7, 1946
and that I last saw him alive on November 6, 1946

Immediate cause of death

Coronary occlusion

DURATION

Due to

Due to

Other conditions

pernicious anemia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

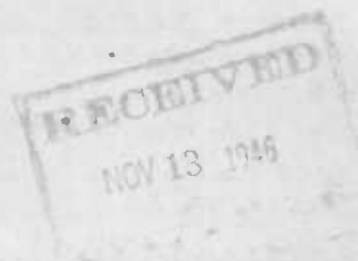
23. SIGNATURE

Elizabeth Bragg, M.D.
Comp, Md. M. D. or otherAddress Comp, Md. Date signed 11/8/46

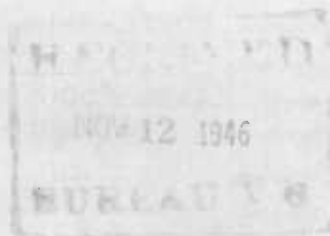
MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 470

CERTIFICATE OF DEATH

★ 10619
Reg. Diat. No. 40

1. PLACE OF DEATH

County AlleganyCity or town Cambsburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

45 Canal St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cambsburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 45 Canal St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth Victoria Eaton

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Charles Eaton

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Nov 18, 1873

8. AGE:

Years Months Days If less than one day

77 11 22 hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Homemaker

11. Industry or business

John Conthard

12. Name

Ind.

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mrs. Clarence Murray

Address

Ridgely St. Va.

17. Burial

(Burial, cremation, or removal. Which?)

Burial

Date thereof

11-12-46

(month) (day) (year)

Cemetery or crematory

Sts Peter & Paul Cem.

Location

Cambsburg Ind.

18. Funeral director

Long & Son Inc

Address

Cambsburg

19. Nov. 11, 1946

(Date rec'd by registrar)

Joe P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 1019 46 at 1:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/6 to 11/10and that I last saw him alive on 11/1019 46

Immediate cause of death

lung cancer, heart failurefrom

Due to

from

Due to

from

Due to

from

Other conditions

bronchogenic cancer?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Elizabeth Brown, M.D.

Address

Long, Ind.

Date signed

11/11/46

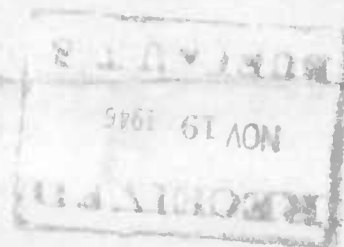
MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

2-31



DR. GROVE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 350

CERTIFICATE OF DEATH

Reg. Dist. No. 11448 40

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLANDCounty ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

MISS PAULINE FRENZEL

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) MAR. 23, 1880

8. AGE:

Years

Months

Days

If less than one day

66718

hrs.

min.

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation

HOUSEWORK

11. Industry or business

FATHER
MOTHER

12. Name

FRENZEL, HENRY

13. Birthplace

MARYLAND

14. Maiden name

WILHELMINA SHUHART

15. Birthplace

MARYLAND

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MD.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Nov 14, 1946
(month) (day) (year)

Cemetery or crematory

Morrison Cem

Location

Reynolds Maryland

18. Funeral director

Edgeworth P. Bond

Address

Electrapper, Md.19. Nov 11, 1946

(Date rec'd by registrar)

J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 11, 1946 at 7:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

NOV. 10, 1946 to NOV. 11, 1946and that I last saw him alive on NOV. 11, 1946

Immediate cause of death

DURATION

Sum of the night
Due to supra meningitis ?
Malignant Dura meningitis ?
Due to Secondary hemorrhage 1 day

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

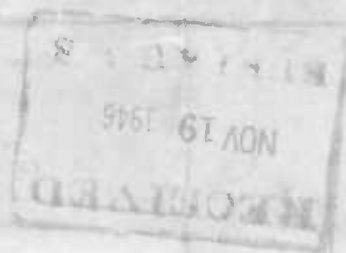
Address

Date signed 11-11-46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incomplete age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

CERTIFICATE OF DEATH

Reg. Dist. No. 10620 40

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 7 Mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 211 Schley St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Meshack S. Frost

3. (b) Social Security Number

None4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Bernadetta Cordial7. Birth date of deceased (mo., day, yr.) Oct. 30, 1873 6. (c) If alive, give age _____ years8. AGE: Years 73 Months 0 Days 8 If less than one day _____ hrs. _____ min.9. Birthplace Frost Station, Md.
(Town, county, and state)10. Usual occupation Clark (Retired)

11. Industry or business

12. Name Meshack A. Frost13. Birthplace Md.14. Maiden name Anna R. Seymour15. Birthplace Md.16. Informant Frank DavisAddress Cumberland, Md.17. Burial Date thereof Nov. 11, 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peter & PaulsLocation Cumberland, Maryland18. Funeral director Louis Stein Inc.Address Cumberland, Md.19. Nov. 9 19 46 Jos. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 19 46 at 4:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 46 to Nov 8 19 46and that I last saw him alive on Nov. 7 19 46Immediate cause of death Acute nephritis
meninges

DURATION

2 daysDue to Arterio Sclerosis 3 yrsDue to Chronic nephritis 12 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. H. Thomas M. D. or otherAddress Cumberland, Md. Date signed 11/8/46

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED
JUN 13 1946
RECEIVED

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-2

CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH:

County Allegany
 City or town Little Orleans (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Washington
 City or town Hancock (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R. 7 D. 1
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sarah Ellen Garland

3. (b) Social Security Number

4. Sex F 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Thymasz R Garland
(deceased)

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1860

8. AGE: Years 86 Months 9 Days 23 If less than one day _____ hrs. _____ min.

8. Birthplace Fulton Co., Pa.
(Town, county, and state)10. Usual occupation House wife11. Industry or business Iron home12. Name William Bishop13. Birthplace Fulton Co., Pa.14. Maiden name Susan Gardner15. Birthplace Fulton Co., Pa.16. Informant Susie BodessAddress Little Orleans, Md.17. Burial Date thereof Dec. 1, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fairview CemeteryLocation Bedford Co., Pa.16. Funeral director Ephraim SmithAddress Artemus, Pa.19. Nov. 29 19 46 T. T. Mann per M. E. Mann
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1946 at 3:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 24 19 46 to Nov. 29 19 46and that I last saw her alive on Nov. 28 19 46Immediate cause of death Pneumonia

DURATION

2 daysDue to Grippe1 week

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

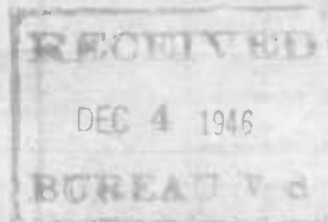
Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE J. A. Watson, M.D.

M. D. or other

Address Little Orleans, Md. Date signed 11/29/46



1-25

2-10 — 1-10

Jacobson.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-6

10623

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 6 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County MineralCity or town Keyser
(If outside city or town limits, write RURAL and give nearest town)Street No. 281 Fort Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Garlitz, Dora Mrs.

3. (b) Social Security Number

234-40-2985

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married6. (b) Name of husband or wife Garlitz, James E.6. (c) If alive, give age 60 years

7. Birth data of

deceased (mo., day, yr.) May 28, 18998. AGE: Years Months Days If less than one day
47 5 16 hrs. min.9. Birthplace West Virginia
(Town, county, and state)10. Usual occupation Housewife
(Life Insurance Agent)

11. Industry or business

12. Name Fortney, Buchner13. Birthplace West Virginia14. Maiden name Mollie Rogers15. Birthplace West Virginia16. Informant Memorial HospitalAddress Cumberland, Maryland.17. Burial Date thereof 11/17/1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory xxx Queens PointLocation Keyser, W. Va.18. Funeral director B. W. MarkwoodAddress Keyser W. Va.19. Nov. 17, 1946 Joseph D. Smith, Jr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1946, at 9:55pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased on

November 14, 1946 to Nov. 14, 1946and that I last saw her alive on Nov. 14, 1946

Immediate cause of death

Myocardial FailureDue to Myocardial FailureArteriosclerosisDue to Coronary SclerosisMyocardial Failure

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph D. Smith, Jr. M. D. or otherAddress 15 Liberty St. Date signed 11/15/46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15N

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 26 1946

RECEIVED

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 106-20

CERTIFICATE OF DEATH

★ 10622 90

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegheny
City or town Leathung
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

80 C. Mechanic St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County MarionCity or town Quilts, Ind
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Patrick Lee Garlitz

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

October 18, 19466. (c) If alive, give age ✓ years

8. AGE:

Years

Months

Days

If less than one day

112

hrs.

min.

9. Birthplace

Leathung, Alleg. Ind
(Town, county, and state)

10. Usual occupation

Child

11. Industry or business

12. Name

Patrick Forrest Garlitz

13. Birthplace

Quilts, Ind

14. Maiden name

Myrtle Ann McKenzie

15. Birthplace

Cumberland Ind.

16. Informant

Mr. Patrick F. Garlitz

Address

Quilts, Ind.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Quilts St. James Cem.

Location

Quilts, Ind.

18. Funeral director

Wm. W. Wintling

Address

Laurensville, Ind.19. 11-3019 46Mr. Xoney A. Roe

(Data rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1946 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 30, 1946 to November 30, 1946and that I last saw him alive on November 30, 1946

Immediate cause of death

Acute Bronchitis

DURATION

1 day

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. C. Dick M.D.

M. D. or other

Address

Leathung, Ind.

Date signed

11/30/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 3 1946

BUREAU V. C.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 112

CERTIFICATE OF DEATH

10624

Reg. Diat. No. 90

1. PLACE OF DEATH:

County allegany
 City or town 3 southway
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Miner Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md. County allegany
 City or town 3 southway
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 101 Walnut
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

John Greening

3. (b) Social Security Number

213-10-9712

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Annice Greening

6. (c) If alive, give age

53 years

7. Birth date of deceased (mo., day, yr.)

Dec. 7, 1887

8. AGE:

59

Years

11

Months

9

Days

If less than one day

hrs.

min.

9. Birthplace

Stales

(Town, county, and state)

10. Usual occupation

Miner

11. Industry or business

coal

FATHER

12. Name

Paul John Greening

13. Birthplace

Stales

MOTHER

14. Maiden name

Maria Jones

15. Birthplace

Stales

16. Informant

Raymond Greening

Address

3 southway, 1 md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Dec 1-1946

(month) (day) (year)

Cemetery or crematory

allegany

Location

3 southway, 1 md.

18. Funeral director

J. J. [unclear]

Address

3 southway19. 11-30-46
(Date rec'd by registrar)19-46 Mrs. Nancy A. Roe
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1946 at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 26 1946 to Nov 28 1946and that I last saw him alive on Nov 28 1946

Immediate cause of death

acute cardiac
decelation

DURATION

1 day

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. O. Mc Lane
Address East Pheny Md Date signed 11-29-46

M. D. or other

RECEIVED

DEC 3 1946

BUREAU V 8

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10625

Reg. Diat. No. 40

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 57 years
Hospital, institution, or street address where death occurred:
131 Grand Avenue
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 131 Grand Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

James Anthony Gross

3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Mary Ann "Goldizen" Gross 6. (c) If alive, give age None years

7. Birth date of deceased (mo., day, yr.) April 17, 1857

8. AGE: Years 89 Months 7 Days 3 If less than one day hrs. min.

9. Birthplace Morgan Co., W. Va.
(Town, county, and state)

10. Usual occupation Retired Rail Road Conductor

11. Industry or business B. & O. Railroad

12. Name Henry Gross

13. Birthplace Unknown

14. Maiden name Mary Gates

15. Birthplace Unknown

16. Informant George W. Gross

Address 134 Arch St. Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof November 22, 1946
(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Maryland

18. Funeral director John J. Water

Address Cumberland, Maryland

19. Nov 22 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 19 46 at 7:55 A.M.

21. I CERTIFY that death occurred on the date above stated, that it followed deceased from Jan 1 19 46 to Nov 20 19 46 and that I last saw deceased alive on Nov 18 19 46

Immediate cause of death Chronic myocarditis DURATION 2 yrs

Due to Chronic myocarditis

Due to Chronic myocarditis

Other conditions Atherosclerosis 2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. A. Treuskis Sr., M.D. M. D. or other

Address Cumberland, Md Date signed Nov 20-46

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 26 1946

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

10626

Kights

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. North Branch
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Hamilton, Frank Mr.4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) September 22, 76.8. AGE: Years 70 Months 1 Days 21 If less than one day hrs. min.9. Birthplace West Virginia
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Charles M. Hamilton13. Birthplace West Virginia14. Maiden name Elizabeth Ashkettle15. Birthplace Maryland16. Informant Memorial HospitalAddress Cumberland, Maryland.17. Burial Date thereof 11/16/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hill Crest CemeteryLocation Cumberland Md18. Funeral director William H KightAddress Cumberland, Md.19. Nov. 15 1946 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1946 at 9:10p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 11, 1946 to Nov. 13, 1946
and that I last saw him alive on Nov. 13, 1946Immediate cause of death Generalized arteriosclerosis DURATION 5 yrs.Due to Generalized arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles M. Hamilton M. D. or otherAddress Cumberland Date signed 11/13/46

1-31-
RECEIVED
NOV 19 1966

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12220

CERTIFICATE OF DEATH

Reg. Dist. No. 10627 40

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Allegheny Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pennsylvania County Bedford
 City or town Hyndman, Pa
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Katie Tenia Harclerode

3. (b) Social Security Number

None

4. Sex Fe 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 1 1879

8. AGE: Years 67 Months 9 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace Hyndman, Pa.
 (Town, county, and state)

10. Usual occupation House work

11. Industry or business _____

12. Name Jonathan Harclerode13. Birthplace Pa.14. Maiden name Annie Miller15. Birthplace Pa.16. Informant Charles HarclerodeAddress Hyndman, Pa.17. Burial Date thereof Nov. 20, 1946

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Hyndman, Pa.Location Hyndman, Pa.18. Funeral director Harvey H. ZeiglerAddress Hyndman Pa.19. Nov. 19 19 46

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 19 46 at 7PM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 15 19 46 to Nov 17 19 46and that I last saw him alive on Nov 17 19 46

Immediate cause of death _____

DURATION

Submarginal embolus 1 hr.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Strangulation ileumthrombosed hemorrhoids Date of op. Nov 16, 1946

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John A. Zupper MD

M. D. or other _____

Address Hyndman Pa. Date signed 4/17/46

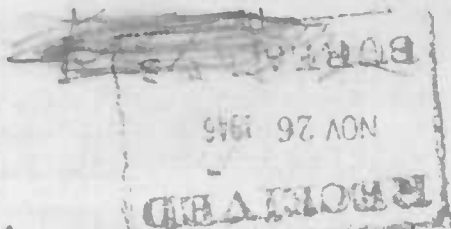
MARGIN RESERVED FOR BINDING

VS A15 9.45:15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 66

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 days
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD. County ALLEGANY
 City or town Near CUMBERLAND Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. RFD #3, VALLEY ROAD
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

HARPER, RAYMOND ~~ASHLEY~~ Ashbee

3. (b) Social Security Number

None

4. Sex MALE 5. Color or race W 6. (a) Single, married, widowed, or divorced SINGLE
 6. (b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.) Oct 9, 1944 6. (c) If alive, give age..... years
 8. AGE: Years 2 Months 1 Days 16 If less than one day
hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)10. Usual occupation INFANT

11. Industry or business

12. Name HARPER, HARLON A.13. Birthplace W. VA.14. Maiden name DICKEN, CLEONA15. Birthplace MD.16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial Date thereof November 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Teter CemeteryLocation Banman's Addt, Cumberland, Md.18. Funeral director John J. SpillerAddress Cumberland, Maryland19. Nov. 27, 1946 J. L. Munkley, M.D.
(Date rec'd by registrar) Registrar

DR. O. L. OWENS

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 19 46 at 5 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov 13 19 46 to Nov 25 19 46
and that I last saw him alive on Nov 25 19 46Immediate cause of death Heart Failure - Coronary Artery Disease
DURATION 6 mos

Due to.....

Due to.....

Other conditions Arteriosclerosis 3 mos

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. noneAutopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE O. L. Owens M.D. M. D. or otherAddress Cumberland, Md. Date signed 11-26-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15N

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 3 1946

BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore



10629

Reg. Dist. No. 40

CERTIFICATE OF DEATH

DR. ELIASON

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town FLINTSTONE
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D. #1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

HELEN LOUISE HARTSOCK

3. (b) Social Security Number

None4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 17, 19468. AGE: Years 3 Months 14 Days 14 If less than one day hrs. min.9. Birthplace CUMBERLAND, MD.
(Town, county, and state)

10. Usual occupation

11. Industry or business INFANT12. Name ROBERT HARTSOCK13. Birthplace MARYLAND14. Maiden name DOROTHY McELFISH15. Birthplace PENNSYLVANIA16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial Date thereof November 2, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Prosperity Christian CemeteryLocation R.F.D. 1, Flintstone, Md.18. Funeral director John J. HefferAddress Cumbersland, Md.19. Nov. 2 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 1 19 46 at 3:40 A.M.21. I CERTIFY that death occurred on the data above stated: that I attended deceased from Oct 31 46 to Nov 1 46and that I last saw him alive on Oct 31 46Immediate cause of death Pneumonia DURATION 10 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. B. Elison M.D. or otherAddress 364 N. W. 1st St. Cumberland Md Date signed 11/1/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and in correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 70

CERTIFICATE OF DEATH

106304
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 7 hours
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? About 7 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Allegany
City or town Flintstone Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D.2
(If rural, give LOCATION)
2. (a) If veteran, name war World War.

3. (a) FULL NAME

Riley D. Heavner

3. (b) Social Security Number

736-20-9434

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____ 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept. 12. 1924

8. AGE: Years 22 Months 2 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Petersburg W. Va.
(Town, county, and state)

10. Usual occupation U.S. Fire Co.

11. Industry or business

12. Name Branson A. Hearner

13. Birthplace W. Va.

14. Maiden name Ethel Goldizer

15. Birthplace W. Va.

16. Informant Branson A. Hearner

Address Flintstone, Ind.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Dec 2 46
(month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Nov 30 19 46 Joseph D. Imbler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 19 46, at 2:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
and that I last saw him alive on Nov. 29 19 46

Immediate cause of death Pulmonary Hemorrhage

Due to punctured lung from fractured ribs

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Auto. Accident Date of 11.28.46

Where did injury occur? near Cumberland Allegany Md.

3 1/2 miles East of Cumberland Md.
(City, town, county) (State)

Injured at home, farm, industry, public place (where?) Route 40

Means of injury Auto. collision Injured at work? no

23. SIGNATURE H. V. Downing M.D. M. D. or other _____

Address Cumberland Md. Date signed 11/29/46

MARGIN RESERVED FOR BINDING

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VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 3 1946

BUREAU U.S.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

★ 10631

DR. GRACIE & OWENS

CERTIFICATE OF DEATH

Reg. Dist. No.

40

1. PLACE OF DEATH:

County.....ALLEGANY.....

City or town.....CUMBERLAND.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?.....12 DAYS.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MARYLAND..... County.....ALLEGANY.....

City or town.....LITTLE ORLEANS.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MRS. EDITH HETTENHOUSER

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FEMALE WHITE MARRIED

6.(b) Name of husband or wife.....JOHN L. HETTENHOUSER.....

7. Birth date of deceased (mo., day, yr.).....FEBRUARY 2, 1892.....
6.(c) If alive, give age.....53.....years8. AGE: Years Months Days If less than one day
54 9 2hrs.min.9. Birthplace.....MARYLAND.....
(Town, county, and state)

10. Usual occupation.....HOUSE WIFE.....

11. Industry or business

12. Name.....McCUSKER, JOHN.....

13. Birthplace.....MARYLAND.....

14. Maiden name.....BARNHART, NAN.....

15. Birthplace.....MARYLAND.....

16. Informant.....MEMORIAL HOSPITAL.....

Address.....CUMBERLAND, MARYLAND.....

17. Burial.....Date thereof.....NOV. 7, 1946.....
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....ST. PATRICK'S CATHOLIC.....

Location.....LITTLE ORLEANS, MD.....

18. Funeral director.....CHARLES R. BAST.....

Address.....HANCOCK, MD.....

19. Nov 5, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....NOV. 4.....1946.....at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1946 to 1946
and that I last saw him/her alive on Nov 4, 1946Immediate cause of death.....Pulmonary embolism.....
Due to.....Atherosclerosis of heart & Coronary artery.....
Due to.....
Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....Aortic aneurysm & relaxed heart.....Date of op. Nov 24-46

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide.....Date of.....
Where did injury occur?.....(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury.....Injured at work?23. SIGNATURE.....H. P. Gracie.....M. D. or other
Address.....Cumberland.....Date signed.....Nov 4-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED
NOV 13 1946
BUREAU

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Allegheny
 City or town Mt. Savage
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years
 Hospital, institution, or street address where death occurred:
Home
 How long in hospital or institution? 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Mt. Savage
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Groundy Row
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Annie Nichols Hotchkiss

3. (b) Social Security Number

1

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Richard C. Hotchkiss 6. (c) If alive, give age 66 years
 7. Birth date of deceased (mo., day, yr.) May 19, 1882
 8. AGE: Years 64 Months 5 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Quakering, Allegheny Co., Md.
(Town, county, and state)10. Usual occupation Housework11. Industry or business Own home12. Name Benjamin F. Nichols13. Birthplace Pennsylvania14. Maiden name Sarah McGee15. Birthplace Scotland16. Informant Richard C. HotchkissAddress Mt. Savage, Md.17. Burial Date thereof Nov 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak Hill CemeteryLocation Quakering, Md.18. Funeral director M. EichlingAddress Quakering, Md.19. Nov 13 19 46 Vernon McDermott
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12th 1946 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945 to Nov. 12th 1946
 and that I last saw him or alive on November 12th 1946

Immediate cause of death Cerebral Hemorrhage -
Due to vascular hypertension.

Due to Chronic Hypertension &
Nephritis -
 (Include pregnancy within 3 months of death)

Major findings of operations Swamp
meas.

Other conditions Swamp
meas.

Major findings of operations Swamp
meas.

Major findings of operations Swamp
meas.

Major findings of operations Swamp
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Major findings of operations Swamp
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Major findings of operations Swamp
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Major findings of operations Swamp
meas.

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NOV 16 1946
BUREAU V R

1-21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

100930

1. PLACE OF DEATH:

County... Allegany...City or town... Frostburg, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?...

Hospital, institution, or street address where death occurred:

How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... 3rd... County... AlleganyCity or town... Frostburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 131 West St.
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife...

Margaret Bond

7. Birth date of deceased (mo., day, yr.)

Aug. 16th. 1895

B.(c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

51219

hrs.

min.

9. Birthplace...

Frostburg, Md
(Town, county, and state)

10. Usual occupation...

Catholic

11. Industry or business

Old St. School

MOTHER FATHER

12. Name

James R. Hughes

13. Birthplace

Frostburg

14. Maiden name

R. Fisher

15. Birthplace

England

16. Informant

John Hughes

Address

76 Spring St.

17.

(Burial, cremation, or removal, Which?)

Date thereof

11-8-1946
(month) (day) (year)

Cemetery or crematory

Allegany

Location

Frostburg, Md

18. Funeral director

J. J. [unclear]

Address

Frostburg, Md

19.

(Date rec'd by registrar)

19.

46Wm. Harvey H. [unclear]
Registrar

3. (b) Social Security Number

219-14-5955

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5 1946, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

19...

19...

end that I last saw him DEAD - Nov 6 1946

Immediate cause of death

Coronary occlusion

DURATION

at once

Due to...

Due to...

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. V. [unclear] M.D.

M. D. or other

Address

Cumberland, MdDate signed 11-6-46

Deputy Medical Examiner - Allegany Co.

RECEIVED
NOV 9 1946
BUREAU V.E.

1-35

71 Long

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

CERTIFICATE OF DEATH

Reg. Dist. No.

10634

90

1. PLACE OF DEATH:

County Allegany
 City or town Fruthtown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 92 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County Allegany
 City or town Fruthtown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 185 E. Main St.
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Leona Jones

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

20. (Date signed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10635

Reg. Dist. No.

40

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 52 Years
Hospital, institution, or street address where death occurred:
721 Greene St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 721 Green St.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

John Fredrick Keifer

3. (b) Social Security Number

705-05-5198

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Eleanor Keifer

6. (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) September 2 1894

8. AGE: Years 52 Months 2 Days 26 It less than one day hrs. min.

9. Birthplace Cumberland, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation Back Shops

11. Industry or business Baltimore & Ohio Railroad

12. Name

13. Birthplace

14. Maiden name Katherine Keifer

15. Birthplace Cumberland, Maryland

18. Informant Mrs. John F. Keifer

Address 721 Greene St., Cumberland, Md.

17. Burial Date thereof 12/2/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Peter & Paul Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Nov 30 1946 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1946 1946, 11.15 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him Dead Nov. 28 1946

Immediate cause of death

Coronary occlusion about 5 minutes

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Cumberland, Md. Date signed 11-29-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 3 1946

BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52

CERTIFICATE OF DEATH

★ 10636 40
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegheny
City or town Cumberland (RURAL)
(If outside city or town limits, write RURAL and give nearest town)
Street No. P. O. Box 193, LaVale
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Hester Keith

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Henry Keith

6. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) March 8, 1895

8. AGE: Years 51 Months 8 Days 2 It less than one day hrs. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Thomas Hickle

13. Birthplace West Virginia

14. Maiden name Amanda Katherine Watts

15. Birthplace West Virginia

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial Date thereof Nov. 13, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Zion Memorial

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. Nov. 18 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1946 at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 3 1946 to Nov. 10 1946 and that I last saw him alive on 10-10-46

Immediate cause of death Pulmonary Tuberculosis DURATION 10 months

Due to Hypertension for
Fibrill.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X Date of X

Where did injury occur? X (City or town) X (County) X (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. H. Hawkins M. D. or other

Address Cumberland Md Date signed 11-12-46

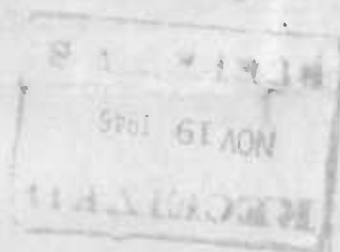
MARGIN RESERVED FOR BINDING

9.45:15M

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-25



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10637

Reg. Dist. No.

90

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 19 yrs.
 Hospital, institution, or street address where death occurred:
mine's Hospital
 How long in hospital or institution? 2 1/4 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Allegany
 City or town Borden P.O. Frostburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Francis Gallop
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 14 - 1897

8. AGE: Years 69 Months 4 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Borden, Allegany, Md.
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Coal Miner

12. Name Iruman, Thomas

13. Birthplace Frostburg, Md.

14. Maiden name Elyabeth Bailey

15. Birthplace Prussia, Pa.

16. Informant Mr. Richard J. Gessup

246 Mechanics St. Frostburg

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 11 - 22 1946
 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Jacobi, David

Address Frostburg, Md.

19. 11-21 46 Mrs. Nancy H. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 19 46 at 3:15 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 41 to 1949 and that I last saw him alive on November 19 19 46.

Immediate cause of death Coronary Thrombosis DURATION 4 days

Due to arteriosclerotic heart disease

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

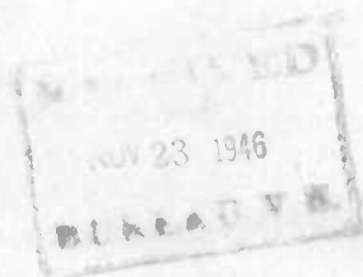
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Hilda Jaurupsky M.D. or other _____

Address Frostburg, Md. Date signed 11/21/46



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-2

CERTIFICATE OF DEATH

Reg. Dist. No. 10638 40

DR. DURRETT
DR. HODGES

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 709 MADISON STREET
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

BABY BOY KIMBLE (PREMATURE)

3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth data of

deceased (mo., day, yr.)

NOVEMBER 18, 1946 12:56 A.M.

8. AGE:

Years

Months

Days

If less than one day

5 hrs. min.

9. Birthplace

Cumberland, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

GLENN KIMBLE

FATHER

12. Name

13. Birthplace

WEST VIRGINIA

MOTHER

14. Maiden name

Mary CAPPS

15. Birthplace

NORTH CAROLINA

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 18, 1946
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Nov. 18, 1946

J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

NOVEMBER 18, 1946 5:56 A.M.

20. DATE OF DEATH 19 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov. 18 46 to Nov. 18 1946

and that I last saw him alive on

Immediate cause of death

Premature
separation of placenta etc.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Memorandum in
uterine wall. Date of op. 11/18/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

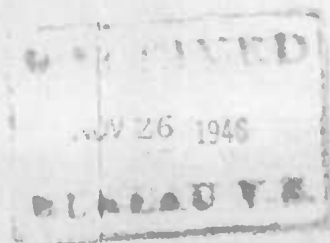
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

W. R. Hodges, M.D.
Cumberland, Md. M. D. or other

Address Date signed 11/18/46



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

Dr. Reeves

Reg. Dist. No. 60

1. PLACE OF DEATH:

County Allegany
 City or town Barton (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 75 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Barton (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Francis Kyle

3. (b) Social Security Number

4. Sex Male 5. Color or race White 8.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Anna Mae Kyle

6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) November 11, 1871

8. AGE: Years 75 Months 0 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Barton, Allegany, Maryland
 (Town, county, and state)

10. Usual occupation Miner11. Industry or business Coal mine

12. Name Frederick Kyle
 13. Birthplace Mathias, W. Va.

MOTHER
 14. Maiden name Harriet Barnes
 15. Birthplace Barton, Maryland

18. Informant Frederick Kyle
 Address Barton, Maryland

17. burial Date thereof 24 Nov 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Laurel Hill Cemetery

Location Moscow, Maryland
Ellsworth S. Boal

18. Funeral director _____
 Address 111 Church St., "esternport, Md.

Nov. 24 19 46 W. S. Barnes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 19 46 at 6:20pm

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Nov. 19 19 46 to Nov 21 19 46
 and that I last saw him Nov 20 19 46

Immediate cause of death Cerebral thrombosis DURATION 1 wk

Due to Chronic pyogenic

Due to and economic

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. S. Barnes M.D. or other _____

Address W. S. Barnes Date signed 11/24/46

RECEIVED
NOV 25 1946
BUREAU VA

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 482

CERTIFICATE OF DEATH

10640

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

Memorial Hospital
How long in hospital or institution? 101 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County allegany
City or town Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Christie Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Lopley

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Oliver Lopley

6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) February 10, 1912

8. AGE: Years 34 Months 8 Days 22 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Anderson

13. Birthplace Maryland

MOTHER 14. Maiden name Minnie Hamilton

15. Birthplace Maryland

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial Burial Date thereof Nov. 5, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Nov. 5, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2, 1946 at 3:18 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-12-45 to 11-2-46

and that I last saw him alive on 10-12-45

Immediate cause of death Carcinoma uterus DURATION 2 1/2 yrs

Due to

Due to

Other conditions Carcinoma uterus 6 mo

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma uterus

uterus Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin, M.D. M. D. or other

Address Cumberland, Md. Date signed 11-4-46

MARGIN RESERVED FOR BINDING

VS Art 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 13 1945

RECEIVED

2-35

D DR. WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122-2

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

12 DAYS
MEMORIAL HOSPITAL

3. (a) FULL NAME

MRS. BRIDGET LOGSDON

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

ALLEN LOGSDON

7. Birth date of deceased (mo., day, yr.)

6/8/1874

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

72

5

2

hrs.

min.

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation

HOUSE WIFE

11. Industry or business

FATHER

12. Name

Anthony Kelly

13. Birthplace

Ireland

MOTHER

14. Maiden name

Bridget Pyle

15. Birthplace

Ireland

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MARYLAND

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 17, 1946
(month) (day) (year)

Cemetery or crematory

St. Patrick's

Location

Cumberland, Md.

18. Funeral director

Louis Stein Inc.

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

Nov. 17, 1946

J. P. Franklin, M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYIA ND County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 108 COLUMBIA ST.,
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 10 1946 at 7:12 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCT. 29 1946, to NOV. 10 1946.and that I last saw him AT alive on NOV. 10 1946.

Immediate cause of death

DURATION

acute dilatation
heart failure
 Due to myocarditis
operated dilatation
obstruction
 Other conditions due to old adhesions
Not due to cancer, C.U.B.R.
 (Include pregnancy within 3 months of death)

Major findings of operations intestinal obstructionAutopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

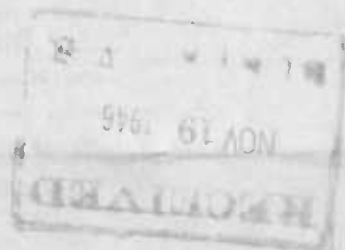
23. SIGNATURE..... M. D. or other

Address..... Date signed 11-18-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In direct age is especially important. Physicians: please write the causes of death clearly and legibly.



Outside of
City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1940

CERTIFICATE OF DEATH

Reg. Dist. No. 10642 40

1. PLACE OF DEATH:

County Allegany
City or town Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs
Hospital, institution, or street address where death occurred:
Shanks Lane & Route 40, LaVale
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Allegany
City or town LaVale, Near Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Shanks Lane & Route 40
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Paul Wm Marriott

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Rachael Miller
6. (c) If alive, give age 82 years
7. Birth date of deceased (mo., day, yr.) April 15, 1870
8. AGE: Years 76 Months 6 Days 17 If less than one day

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2, 1946, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/30, 1946, to 11-1, 1946, and that I last saw him alive on 11-1, 1946.
Immediate cause of death Cardiovascular DURATION

9. Birthplace Westport, Allegany Co., Md.
10. Usual occupation Retired Bookkeeper
11. Industry or business Wholesale Grocery
12. Name John Marriott
13. Birthplace Howard County, Md.
14. Maiden name Julia Barrett
15. Birthplace Howard County, Md.
16. Informant Oliver Marriott
Address Route 1, Cumberland, Md.
17. Burial SOO F Cemetery
(Burial, cremation, or removal. Which?) Date thereof Nov 5, 1946
(month) (day) (year)
Cemetery or crematory Westernport, Md.
Location John J. Hafer
18. Funeral director Cumberland, Md.
Address Nov. 5, 1946
19. (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Due to Atherosclerosis
Due to

Other conditions Parkinson's disease
enlarged prostate
(Include pregnancy within 3 months of death)
Major findings of operations L
Date of op.
Autopsy results L
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE J. P. Franklin M. D. or other
Address 132 Bedford St Date signed 11/9/46

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
13 1946

2-35

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (69)

CERTIFICATE OF DEATH

Reg. Dist. No. 40

10643

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State XXXXXXX MD County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 810 MAPLEWOOD AVE, CITY
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

BABY GIRL McCULLOUGH

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALEWHITESINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 5, 19468. AGE: Years Months Days If less than one day
2 hrs. min.9. Birthplace MARYLAND, Cumberland, Alleg. Co.
(Town, county, and state)10. Usual occupation NEW BORN

11. Industry or business

12. Name McCULLOUGH, WILLIAM13. Birthplace MARYLAND14. Maiden name TWIGG, MARY ALICE15. Birthplace MARYLAND16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MARYLAND17. Cremation Date thereof Nov. 8, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Memorial Hosp.Location Cumberland, Md.18. Funeral director Same as above

Address

19. Nov. 8, 46 Joe P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 7 19 46 at 7:55 Pm21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 5 19 46 to Nov. 7 19 46 and that I last saw him alive on Nov. 5 19 46

Immediate cause of death

Prematurity

DURATION

6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cumberland, Md. Date signed 11/8/46

MARGIN RESERVED FOR BINDING

VS A15 9.45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 13 1946
U. S. AIR FORCE

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 106-15

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
9 Charles St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 9 Charles Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Peter S. McGuire

3. (b) Social Security Number

none

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Margaret McGuire
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Nov. 12 - 1870
 8. AGE: Years 76 Months 05 Days 10 If less than one day _____ hrs. _____ min.
 9. Birthplace Barton - Alleg - MD
 (Town, county, and state)

10. Usual occupation ret d

11. Industry or business

FATHER
 12. Name Patrick McGuire
 13. Birthplace Ireland
 MOTHER
 14. Maiden name Ann McCrory
 15. Birthplace Ireland
 16. Informant Mrs George Lippen
 Address Frostburg MD
 17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Nov. 25-1946
 (month) (day) (year)
 Cemetery or St. Michael's
 Location Frostburg
 18. Funeral director J. F. D. Hunt
 Address Frostburg MD
 19. 11-25-46 Wm. Stanley N. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1946 at 5:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 12 1946 to Nov 22 1946 and that I last saw him alive on Nov 22 1946

Immediate cause of death arteriosclerosis DURATION years

Due to the Bronchitis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wm. Stanley N. Roe M. D. or other _____Address Frostburg MD Date signed 11-24-46

RECEIVED

NOV 27 1946

BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 123

CERTIFICATE OF DEATH

Reg. Dist. No. 10645

1. PLACE OF DEATH:

County Allegany
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 121 Roberts Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Roland O. Mease

3. (b) Social Security Number

705-05-1755

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Vesta Gallaher
6. (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) February 28, 1884

8. AGE: Years 62 Months 8 Days 12 If less than one day
hrs. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual occupation Carpenter Foreman

11. Industry or business Baltimore & Ohio Railroad

12. Name David Mease

13. Birthplace Pennsylvania

14. Maiden name Amelia Goss

15. Birthplace Pennsylvania

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial Date thereof Nov. 13, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland, Md

18. Funeral director Charles L. George

Address Cumberland, Md

19. Nov. 12 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1946 at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 4 to Nov 10 and that I last saw him alive on Nov 10

Immediate cause of death

Cerebral hemorrhage
due to arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin, M.D. M. D. or other

Address Cumberland Date signed 11/12/46

2-30

RECEIVED
NOV 19 1945
STATION



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 169

CERTIFICATE OF DEATH

Reg. Dist. No. 10646 40

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

4 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 201 1/2 Mary St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

James Vernon Mellott

3. (b) Social Security Number

218-12-5953

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Eva Landers Mellott

7. Birth date of deceased (mo., day, yr.)

May 24, 1924

6. (c) If alive, give age..... years

8. AGE:

Years 22Months 5Days 8

If less than one day

..... hrs. min.

9. Birthplace

Harpers Ferry, W. Va.

(Town, county, and state)

10. Usual occupation

Brakeman

11. Industry or business

Western Maryland R.R. Co.

FATHER

12. Name

Corder Mellott

13. Birthplace

Buck Valley, Penna.

MOTHER

14. Maiden name

Bessie Piper

15. Birthplace

Blue Ridge, Va.

16. Informant

Mrs. Eva MellottAddress 201 1/2 Mary St. Cumberland, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 5, 1946

(month) (day) (year)

Cemetery or crematory

Luthern Cemetery

Location

Harpers Ferry, W. Va.

16. Funeral director

Charles L. George

Address

Cumberland, Md.

19.

Nov. 5, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1946 at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 2, 1946 to Nov. 2, 1946and that I last saw him Nov. 2, 1946 alive on

Immediate cause of death

Hemorrhagic shock
angetation of both
eye.

DURATION

4 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11-3-46Where did injury occur? Subway tunnel (City or town) 3 1/2 (State)Injured at home, farm, industry, public place (where?) SubwayMeans of injury Ran over by train Injured at work? yes

23. SIGNATURE

J. P. Franklin, M.D. M. D. or other 11-4-46
Address Medical Bldg Date signed

RECEIVED

NOV 9 1946

BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-6

CERTIFICATE OF DEATH

10647

Reg. Dist. No.

40

1. PLACE OF DEATH:

County allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 75 yrs

Hospital, institution, or street address where death occurred:

804 Columbia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 804 Columbia Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mrs. Jessie Verlinda Metzger

3. (b) Social Security Number

None4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Harry E. Metzger7. Birth date of deceased (mo., day, yr.) June 15, 18708. AGE: 76 Years 5 Months 11 Days hrs. min.9. Birthplace Wheeling, Ohio Co., W. Va.
(Town, county, and state)10. Usual occupation Housework11. Industry or business at home12. Name Edward J. Keller13. Birthplace Fort Ashby, W. Va.14. Maiden name Ruth E. Simpkins15. Birthplace Cumberland, Md.16. Informant E. J. Wellington MetzgerAddress 804 Columbia Ave - Cumberland, Md.17. Burial Date thereof Nov. 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland, Md.18. Funeral director John J. HaferAddress Cumberland, Md.19. Nov. 27 19 46 Je P. Hankins, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 19 46 at 5:20 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 19 46 to Nov 26 19 46and that I last saw him alive on Nov 19 46Immediate cause of death Chronic ulcerative phthisisaffecting skin & lymph glandsDue to Chronic

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Downing, M.D.
M. D. or otherAddress Cumberland, Md. Date signed 11-27-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 3 1946

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH



10648

Dr Reeves 6
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 Years
Hospital, institution, or street address where death occurred:
48 Main Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 48 Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Eva Myrtle Morrison

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife William Morrison 6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) March 18, 1885
8. AGE: Years 61 Months 8 Days 6 If less than one day _____ hrs. _____ min.
9. Birthplace Elk Garden, Mineral, W. Va.
(Town, county, and state)
10. Usual occupation house work
11. Industry or business own home
FATHER 12. Name John Ross
13. Birthplace VIRGINIA
MOTHER 14. Maiden name ANNA A. HOLIDAY
15. Birthplace CLARKSBURG, W. VA.

16. Informant Mrs Joseph Conroy
Address Westernport, Maryland
17. burial Date thereof Nov. 27, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Philos Cemetery
Location Westernport, Maryland
18. Funeral director Ellsworth S. Deal
Address 111 Church St., Westernport, Md.
19. Nov. 26 19 46
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 19 46 at 9:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/24/46 19 to 11/24 19
and that I last saw him alive on 11/24/46 19

Immediate cause of death

Coronary Thrombosis

DURATION

12 hr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Dr Reeves M.D. or other
Address Westernport, Md Date signed 11/26/46

RECEIVED
JUN 29 1946
BUREAU V.E.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

10649

40

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 years

Hospital, institution, or street address where death occurred:

209 South Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 209 Potomac Street
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Reuben O. Morton

3. (b) Social Security Number

214-07-5898

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

B. (b) Name of husband or wife

Olive (Bradley) Morton

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) April 16, 1885

8. AGE:

Years

Months

Days

If less than one day

6173

hrs.

min.

9. Birthplace

Lonaconing, Allegany, Maryland

(Town, county, and state)

10. Usual occupation

Retired Foreman

11. Industry or business

Celanese Corp. of America

FATHER

12. Name

John Morton

13. Birthplace

Scotland

MOTHER

14. Maiden name

Elizabeth Crosser

15. Birthplace

Scotland

16. Informant

Mrs. Olive Bradley Morton

Address

209 South St. Cumberland, Md.

17.

BurialDate thereof Nov. 22, 1946
(month) (day) (year)

Cemetery or crematory

Hillcrest Burial Park

Location

Cumberland, Md.

18. Funeral director

William H. Kight

Address

Cumberland, Md.

19.

Nov. 22, 1946
(Date rec'd by registrar)

19. 46

Joseph D. Brubaker, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1946 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2:13 to 11:19 1946and that I last saw him alive on 11:19 1946

Immediate cause of death

DURATION

Coronary Thrombosis
Generalized
arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. F. Williams
Address Cumberland Date signed 11-22-46

RECEIVED

NOV 26 1946

RECEIVED

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 115 COLUMBIA ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MRS. MARGUERITE NICHOLS

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE WHITE MARRIED

6.(b) Name of husband or wife JOSEPH NICHOLS

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 14, 1902

8. AGE: Years Months Days If less than one day
44 7 1 hrs. min.

9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name OWEN WILSON

13. Birthplace WEST VIRGINIA

14. Maiden name OLIVIA HINKIN

15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial Date thereof Nov. 18, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Burial Park

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Nov. 18, 46 J. P. Franklin M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 15, 1946 at 1:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOV. 13, 1946 to NOV. 15, 1946

and that I last saw him or alive on NOV. 15, 1946

Immediate cause of death

Carcinoma of breast

DURATION

19 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation Carcinoma of breast

Date of op. April 19, 45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

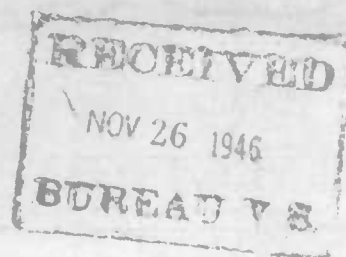
Address Cumberland, Md. Date signed 11-18-46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

10651

Reg. Dist. No. 40

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 115 1/2 ARCH STREET

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

BABY BOY PARK (PREMATURE)

3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 18, 1946

8. AGE:

Years

Months

Days

If less than one day

10 hrs. 16 min.

9. Birthplace CUMBERLAND, ALLEGANY COUNTY, MD.
(Town, county, and state)

10. Usual occupation

11. Industry or business

CHARLES PARK

MOTHER FATHER

12. Name

13. Birthplace

WEST VIRGINIA

14. Maiden name

MARTHA ROWAN

15. Birthplace

MARYLAND

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

46

J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

NOVEMBER 19, 1946

5:40 A.M.

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Mens of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

Handwritten notes, possibly "PI" and "P. 12/11/46".

Handwritten lines, possibly "11/11/46".

Handwritten notes at the bottom left, possibly "11/11/46".

RECEIVED
NOV 26 1946
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2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 40

10652

1. PLACE OF DEATH:

County..... Allegany
City or town..... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? Four months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland County..... Allegany
City or town..... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 520 Virginia Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Shirley Rae Pryor

3. (b) Social Security Number

None

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Single
6.(b) Name of husband or wife.....
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.)..... April 19, 1946
8. AGE: Years..... Months..... Days..... If less than one day..... hrs. min.
6 20

9. Birthplace..... Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation..... Infant

11. Industry or business.....

MOTHER FATHER
12. Name..... Jacob Pryor
13. Birthplace..... Maryland
14. Maiden name..... Shirley Wagus
15. Birthplace..... Maryland

16. Informant..... Jacob Pryor
Address..... Cumberland, Md

17. Burial Date thereof..... Nov. 12, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Rose Hill Cemetery
Location..... Cumberland, Md

18. Funeral director..... John J. Hefner
Address..... Cumberland, Md.

19. Nov. 12, 1946 Registrar..... J. P. Franklin, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 11-9- 1946 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
10-3- 1946 to 11-9- 1946
and that I last saw him alive on 11-8- 1946

Immediate cause of death..... congestive heart failure DURATION..... 6 weeks

Due to..... congenital malformation of heart

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... L. H. Hines MD M. D. or other

Address..... 59 Greene St. Date signed..... 11-9-46

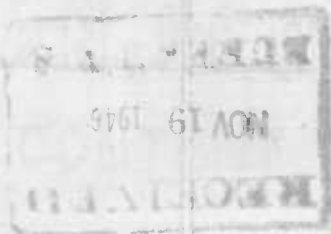
MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

2-35



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 492

CERTIFICATE OF DEATH

10653

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

154 N. Centre St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 154 N. Centre St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Bertha E. (Brant) Randall

3. (b) Social Security Number

214-05-7183

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife David Randall

7. Birth date of deceased (mo., day, yr.) Apr. 22, 1877

8. AGE: Years 69 Months 6 Days 18 If less than one day
..... hrs. min.

9. Birthplace Allegany County, Polish Mt., Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Edward Barnes

13. Birthplace Maryland

14. Maiden name Mary Slider

15. Birthplace Maryland

16. Informant Mrs. Alice Welsh

Address 154 N. Centre St. Cumberland, Md.

17. Burial Date thereof Nov. 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hyndman Cem.

Location Hyndman, Penna.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Nov 14 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1946 at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-19-44 to 11-10-46
and that I last saw h. ev. alive on 10-8-46

Immediate cause of death Carcinoma Vulvae

Due to Carcinomatosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

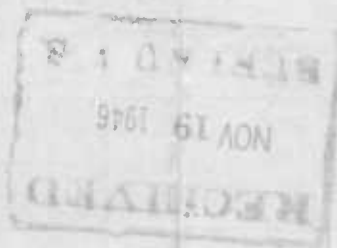
23. SIGNATURE C. E. Sumner, M.D. M. D. or other

Address Cumberland, Md. Date signed 11-12-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 96

CERTIFICATE OF DEATH

Reg. Dist. No. 90

10654

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
Monaca Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Lomacoma Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Park Place
 (If rural, give LOCATION)
 2.(a) If veteran, name war 1

3. (a) FULL NAME

Jennie Young Ravenscroft

3. (b) Social Security Number

1

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Orrin Leonard Ravenscroft

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1890 6. (c) If alive, give age 56 years

8. AGE: Years 56 Months 2 Days 14 If less than one day
 hrs. min.

9. Birthplace Lomacoma, Allegany Co., Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Margie Young

13. Birthplace Scotland

14. Maiden name Agnes F. McMillan

15. Birthplace Vale Summit

16. Informant Mr. Ferdinand Ravenscroft

Address Lomacoma, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Nov. 30, 1946
 (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lomacoma, Md.

18. Funeral director M. Eichhorn

Address Lomacoma, Md.

19. 11-27 46 Mrs. Mauley N. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1946 at 2:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 23 1946 to Nov 27 1946

and that I last saw him alive on Nov 26 1946

Immediate cause of death Ruptured blood vessel of neck evidently

Due to aneurism of large artery

Due to aneurism of large artery

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Lane M. D. or other
 Address Frostburg Md. Date signed Nov 27 1946

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NOV 29 1948
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 10655/8

1. PLACE OF DEATH:

County Allegany
City or town Rural Old Town
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

R.D.#1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Rural Old Town
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D.#1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Robert Wilson Rawlings

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Lillie Whitmire Rawlings

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1865

8. AGE: Years 81 Months 1 Days 18 If less than one day
hrs. min.

6. Birthplace Near Burlington W. Va.
(Town, county, and state)

10. Usual occupation Retired11. Industry or business Farmer12. Name Elijah Rawlings13. Birthplace W. Va.14. Maiden name Hester Ann Welsh15. Birthplace W. Va.16. Informant Mr. Herman RawlingsAddress Old Town, Md.17. Burial Nov. 26, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Porter CemeteryLocation Near Eckhard, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. Nov 26 46 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1946, at 3:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-25-46 to 11-23-46and that I last saw him alive on 11-11-46

Immediate cause of death

arteriosclerosismyocardial degeneration

Due to

Due to

Other conditions fibrosis prostatewith contracture vesical orifice

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard J. TolsonAddress Cumberland, Md. Date signed 11-25-46

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2-35

Within corporate limits DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

10656

Reg. Dist. No. 40

1. PLACE OF DEATH:
 County ALLEGANY
 City or town CUMBERLAND, MARYLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred
Memorial Hospital
 How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State MARYLAND County ALLEGANY
 City or town FLINTSTONE, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Near Flintstone Md.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME FRANK RAY
 3. (b) Social Security Number None

4. Sex MALE
 5. Color or race WHITE
 6.(a) Single, married, widowed, or divorced SINGLE
 6.(b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) UNKNOWN
 6.(c) If alive, give age 1886 years

8. AGE: Years 60
 Months 0 Days 0
 If less than one day 0 hrs. 0 min.

9. Birthplace PA. Bucks Valley, Penna.
 (Town, county, and state)

10. Usual occupation Plasterer

11. Industry or business

FATHER 12. Name FRANK RAY
 13. Birthplace Penna.

MOTHER 14. Maiden name AMANDA BEATTY
 15. Birthplace Penna.

16. Informant James Ray
 Address Artemas, Penna.

17. Burial Burial Date thereof Nov. 21, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Christian Church Cem.
 Location Bucks Valley, Penna.

18. Funeral director H. Wayne George
 Address Cumberland, Md.

19. Nov. 20, 1946 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 18 1946 at 1:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-17-46 to 11-18-46
 and that I last saw him alive on 11-18-46

Immediate cause of death Myocardial degeneration?
+ arteriosclerosis

Due to Chronic pyelonephritis?
 Other conditions Chronic pyelonephritis?
 (Include pregnancy within 3 months of death)

Major findings of operations None
 Date of op. None

Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide None Date of None
 Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None
 Means of injury None Injured at work? None

23. SIGNATURE Howard P. Tolson, M.D.
Cumberland, Md. Date signed 11-18-46
 Address Cumberland, Md.

MARGIN RESERVED FOR BINDING

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9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 26 1946

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

★ 10657

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH:

County AlleganyCity or town Midland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 yrsHospital, institution, or street address where death occurred: home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Midland
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Miss Annie A. Reilly

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.)

March 11, 1888

8. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

58722

hrs.

min.

9. Birthplace Ocean, Allegany Co., Md.
(Town, county, and state)10. Usual occupation School Teacher11. Industry or business Allegany Co. Public School12. Name Michael Reilly13. Birthplace Ishles14. Maiden name Mary Kerney15. Birthplace Ireland16. Informant Miss B. ReillyAddress Midland Md.17. Burial Date thereof Nov 6, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Michael's CemeteryLocation Prosthers Md18. Funeral director M. CliftonAddress Lonaconing, Md.19. Nov 5 19 46 Jannette M. Boal
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1946 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 _____ to 19 _____

and that I last saw her Dead Nov. 3 1946

Immediate cause of death

Chronic MyocarditisDURATION
several
years

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or other _____Address Cumberland Md Date signed 11-4-1946
Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15 9-45-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 8 1946
BUREAU V.B.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

★ 10658
40
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? a few minutes

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? a few minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va County Hardy County

City or town Moorefield, W. Va.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Le Roy Riggleman

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug. 31 1946

8. AGE: Years Months Days If less than one day
2 28 _____ hrs. _____ min.

9. Birthplace Moorefield, Hardy County, W. Va.
(Town, county, and state)

10. Usual occupation None

11. Industry or business _____

FATHER 12. Name Unknown

13. Birthplace ??

MOTHER 14. Maiden name Fleta Riggleman

15. Birthplace Moorefield, W. Va.

16. Informant Fleta Riggleman

Address Moorefield, W. Va.

17. Burial Date thereof Dec. 2, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Newhouse Cemetery

Location Moorefield, W. Va.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Nov 30, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 19 46 at 4.20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
and that I last saw him in alive Dead Nov 29 19 46

Immediate cause of death Pulmonary oedema DURATION about 3

Due to malnutrition and premature months
when born

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. after

Address Cumberland Md Date signed 11/29/46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correctly. It is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 3 1946
BUREAU 78

1-35

Dr. Burnett
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 940
CERTIFICATE OF DEATH

10659
★
Reg. Dist. No. 40

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80 Years
Hospital, institution, or street address where death occurred:
307 Baltimore Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 307 Baltimore Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Hannah Belle Ring
3. (b) Social Security Number None

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife C. S. Ring
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14 1866

8. AGE: Years 80 Months 5 Days 14 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business Own House

12. Name Jacob Rice

13. Birthplace Cumberland, Md.

14. Maiden name Rebecca Thorp

15. Birthplace Cumberland, Md.

16. Informant Mrs. D. L. Taylor
Address 307 Balto Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 12/1/46
(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Nov. 29 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1946 at 1-25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 28 1946 to Nov. 28 1946 and that I last saw her alive on Nov. 28 1946

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clayton J. Sumner
M. D. or other
Address Cumberland Date signed 11/29/46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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Within corporate limits
17 Nov 46

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 1257P
CERTIFICATE OF DEATH

1066040
Reg. Diat. No.

1. PLACE OF DEATH:
County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68 years
Hospital, institution, or street address where death occurred:
Allegheny Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 455 Walnut St.
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME George H. Schultz
3. (b) Social Security Number None

4. Sex M
5. Color or race W
6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Rachel E. Humberson

6. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) March 23, 1878

8. AGE: Years 68 Months 7 Days 12 hrs. _____ min.

9. Birthplace Cumberland, Allegheny Co., Md.
(Town, county, and state)

10. Usual occupation Transfer

11. Industry or business Own Business

12. Name George Schultz

13. Birthplace Germany

14. Maiden name Christina Schade

15. Birthplace Germany

16. Informant Mrs. Rachel E. Schultz
Address 455 Walnut St.

17. Burial Date thereof Nov 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Lukes Lutheran Cem.

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Nov 8, 1946
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1946 at 11:52 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 1946 to Nov 5 1946 and that I last saw him alive on Nov 5 1946

Immediate cause of death Acute Hepatitis with Cholemia 3 days

Due to Acute Hepatitis with Jaundice

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE William E. Korman, M.D.
M. D. or other _____

Address Cumberland, Md. Date signed Nov 7/46

MARGIN RESERVED FOR BINDING

I

9-45-13

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Inclose age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 13 1946
BUREAU OF

1-35

Within corporate limits

DR. ELIASON
DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

★ 10661

Reg. Dist. No. 40

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 708 COLUMBIA AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Joseph Wm. Schupfer Jr.

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALEWHITESINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 29, 19468. AGE: Years Months Days If less than one day
0 28 hrs. min.9. Birthplace MARYLAND, Cumberland, Allegany Co.
(Town, county, and state)10. Usual occupation INFANT

11. Industry or business

12. Name JOSEPH WM. SCHUPFER13. Birthplace MARYLAND, Cumberland14. Maiden name MARIE E. Davis15. Birthplace WEST VIRGINIA, Morgantown16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial Date thereof Nov. 27, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Sts. Peter & PaulLocation Cumberland, Md.18. Funeral director John G. HaderAddress Cumberland, Md.19. Nov. 27, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 26, 1946 11:55 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
NOV. 18, 1946 to NOV. 26, 1946and that I last saw him alive on NOV. 26, 1946Immediate cause of death Pyloric stenosis
PrematurityDURATION
2 hrs

Due to

Due to

Other conditions abdominal hemorrhage 3 days

(Include pregnancy within 8 months of death)

Major findings of operations Pyloric stenosisDate of op. 11/22/46Autopsy results Hemorrhage from ulcerationPHYSICIAN: Please underline the cause to which death should be charged infarction

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin, M.D. M. D. or otherAddress Cumberland, Md. Date signed 11/27/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 3 1946

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

10662 90
Reg. Dist. No.

1. PLACE OF DEATH:

County AlleghenyCity or town Frostburg, Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Oct 26, 1946

Hospital, institution, or street address where death occurred:

Miners HospitalHow long in hospital or institution? 9 hrs - 4 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa County SomersetCity or town Russell
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D. 3 Meyersdale
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Herman Shockley

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Susan Werner Shockley7. Birth date of deceased (mo., day, yr.) Sept. 22, 18656. (c) If alive, give age 82 years8. AGE: Years 81 Months 1 Days 10 If less than one day
.....hrs.min.9. Birthplace Somerset Co
(Town, county, and state)10. Usual occupation Retired Farmer

11. Industry or business

12. Name Eli Shockley13. Birthplace Somerset Co. Pa.14. Maiden name Maragot Mazer15. Birthplace Somerset Pa.16. Informant Mrs. F. F. GlassAddress Bowell, Pa.17. Burial Date thereof Nov. 5, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory White Oak Cemetery - Meyersdale, Pa.Location Meyersdale Pa. R.D. 318. Funeral director Stellman Bros. Inc.Address Meyersdale, Pa.19. 11-2 19 46 Mrs. Nancy H. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 19 46, at 7:40 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
10-26 19 46, to 11-2 19 46
and that I last saw him alive on November 7 19 46Immediate cause of death Carcinoma recti: chuk
& metastases to stomach

DURATION

2 yrs.
3 wks.

Due to.....

Due to SenileOther conditions Arterio-sclerosis

(Include pregnancy within 8 months of death)

Major findings at operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE H.C. Diehl, M.D.
M. D. or otherAddress Frostburg, Md Date signed 11/2/46

CERTIFICATE OF DEATH

1-35

RECEIVED
JUL 5 1946
BIRMINGHAM

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Dist. No. 10663 80

1. PLACE OF DEATH:

County... Allegheny
 City or town... Lawrenceburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 45 years
 Hospital, institution, or street address where death occurred:
Jackson
 How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Allegheny
 City or town... Lawrenceburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Jackson Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

Ella Lora Frederick Sloan

3. (b) Social Security Number

Sloan

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife James Muir Sloan

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) July 6, 1851

8. AGE: Years 95 Months 4 Days 13 If less than one day

9. Birthplace Berlin, Pennsylvania
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

12. Name John Frederick

13. Birthplace Germany

14. Maiden name Anna Eckhardt

15. Birthplace Germany

16. Informant Miss Florence Sloan

Address Lawrenceburg, Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Nov. 21, 1946
 (month) (day) (year)

Cemetery or crematory Allegheny Cemetery

Location Westbury, Md.

18. Funeral director M. E. Pickhorn

Address Lawrenceburg, Md.

19. Nov 20 19 46 Jannette M. Boal
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 19 46, at 12:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7 19 46, to Nov. 12 19 46

and that I last saw him alive on Nov. 18 19 46

Immediate cause of death arterio sclerosis

Due to old age

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry M. Hodges M. D. or other

Address Lawrenceburg, Md. Date signed Nov 20 1946

RECEIVED
JUN 23 1945
BUREAU OF

1-33

Within corporate limits

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *ST-P*

CERTIFICATE OF DEATH

Reg. Dist. No. *10664* *40*

1. PLACE OF DEATH:

County *ALLEGANY*City or town *CUMBERLAND, MD.*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

*MEMORIAL HOSPITAL*How long in hospital or institution? *16 DAYS*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *WEST VIRGINIA* County *TAYLOR*City or town *GRAFTON*
(If outside city or town limits, write RURAL and give nearest town)Street No. *ETHEL ST.*
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MR. D. GRANT SMITH

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

*MALE**WHITE**WIDOWED*6. (b) Name of husband or wife *VIRGINIA PORTER*

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) *? ? ?*8. AGE: Years Months Days If less than one day
80 *>* *>* *>* *hrs. min.*9. Birthplace *WEST VIRGINIA*
(Town, county, and state)10. Usual occupation *PRINTER*

11. Industry or business

12. Name *WILLIAM SMITH*13. Birthplace *MARYLAND*14. Maiden name *Unknown*

15. Birthplace

16. Informant *MEMORIAL HOSPITAL*Address *CUMBERLAND, MD.*17. *Burial* Date thereof *Nov 13 46*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Grafton N.Y.*Location *"*18. Funeral director *Bartlett Funeral Home*Address *Grafton N.Y.*19. *Nov 13 46* *J. P. Franklin, M.D.*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *NOVEMBER 13* *1946* at *3:05 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-28-46 to *11-13-46*and that I last saw him alive on *11-12-46*Immediate cause of death *Carcinoma Prostate* DURATION

Due to

Due to

Other conditions *arteriosclerosis*

(Include pregnancy within 3 months of death)

Major findings of operations

perineal prostatic resection Date of op. *11-11-46*

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

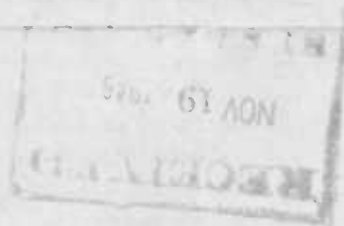
Means of injury Injured at work?

23. SIGNATURE *Howard L. Tolson* M. D. or otherAddress *Cumberland Md* Date signed *11-13-46*

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 96-2

CERTIFICATE OF DEATH

10665 40
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

235 Humboldt St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 527 Rose Hill Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Rose Smith

3. (b) Social Security Number

None4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Joseph Smith
6.(c) If alive, give age 94 years7. Birth date of deceased (mo., day, yr.) Dec 3, 18738. AGE: Years 72 Months 11 Days 12 It less than one day hrs. min.9. Birthplace Carnegie, Allegheny Co. Pa.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business At Home12. Name Gottlieb Hall13. Birthplace Carnegie, Pa.14. Maiden name Unkubwin

15. Birthplace

16. Informant Mrs. Hattie KirkAddress 800 Columbia Ave - Cumb Md.17. Burial Date thereof Nov 18, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peter & Paul CemeteryLocation Cumberland, Md.18. Funeral director John D. HallerAddress Cumberland, Md.19. Nov 17, 1946 J. P. Banker M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 19 46 at 12:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 46 to 19 46and that I last saw h. at home Nov 15 19 46Immediate cause of death Carcinoma of the descending colon

DURATION

several years.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

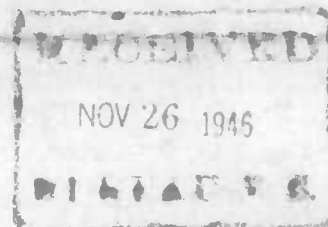
Means of injury Injured at work?

23. SIGNATURE H. K. Downing M.D. M. D. or otherAddress Cumberland Md. Date signed 11/16/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)



10666

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegheny
City or town Butterfield
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 67 yrs

Hospital, institution, or street address where death occurred:

437 Walnut St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny
City or town Butterfield
(If outside city or town limits, write RURAL and give nearest town)Street No. 437 Walnut St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Wilhelmina F Smith

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Charles Smith

7. Birth date of

deceased (mo., day, yr.)

April 15 1884

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

67621

hrs.

min.

9. Birthplace

Butterfield Ind.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

At Home

FATHER

12. Name

George Hindermuth

13. Birthplace

Ind.

MOTHER

14. Maiden name

Wilhelmina Borchers

15. Birthplace

Ind.

16. Informant

Chas Smith

Address

Butterfield

17. Burial

(Burial, cremation, or removal. Which?)

11-9-46
(month) (day) (year)

Cemetery or crematory

Burnside Cem

Location

Butterfield

18. Funeral director

Louis Stein Inc

Address

Butterfield

19. Nov 9

(Date rec'd by registrar)

19 46

J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 6 1946 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 6 1946 to — 19 —and that I last saw her alive on November 6 1946

Immediate cause of death

Cerebral hemorrhage

Due to

Atherosclerosis

Due to

Diabetes, moderate, with acidosis & ketosis
(Include pregnancy within 8 months of death)

Other conditions

Diabetes, moderate, with acidosis & ketosis

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Arnell G. Weisman M.D.
M. D. or other

Address

Cresaptown, IndDate signed 7 Nov 1946

RECEIVED
NOV 13 1948
NY 11

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12

CERTIFICATE OF DEATH

Reg. Dist. No. *106679*

1. PLACE OF DEATH:

County *allegany*
 City or town *mt Savage / Linstburg*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
miners Hospital
 How long in hospital or institution? *1 day*

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State *md* County *allegany*
 City or town *mt Savage*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *new Row*
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Glenn Elden Snyder

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

*m**w**single*

6. (b) Name of husband or wife

-

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *June 12 - 1935*

8. AGE: Years Months Days If less than one day

*11**5**12*

hrs.

min.

9. Birthplace *mt Savage - alleg - md.*
(Town, county, and state)10. Usual occupation *scholar*

11. Industry or business

12. Name *Frank Snyder*13. Birthplace *Wellensburg, Pa.*14. Maiden name *Margaret Baker*15. Birthplace *Wellensburg, Pa.*16. Informant *Mr Frank Snyder*Address *mt Savage md*17. *Burial* Date thereof *Nov 27 - 1946*
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or *Cemetery* *Methodist*Location *mt Savage md*18. Funeral director *J. J. Plunkett*Address *mt Savage md*19. *11-25-46* (Date rec'd by registrar) *ms. Nancy N. De* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *November 24th 1946 3:30 AM*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *November 18 1946* to *November 24 1946* and that I last saw him alive on *November 24 1946*Immediate cause of death *Tetanus* DURATION *24 hours*Due to *Infection Tetanus / Bacilli from a cut on Rt. knee.*

Due to

Other conditions *none*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

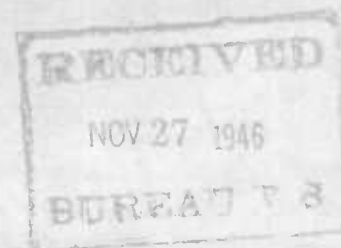
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *William E. Mosley* M. D. or otherAddress *mt Savage md.* Date signed *11-24-46*



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Louis Brings

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(932)

10668

Reg. Diat. No. 5-10

1. PLACE OF DEATH:

County Allegheny
 City or town Cresaptown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:
45 So. Winchester Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny
 City or town Cresaptown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 45 So. Winchester Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

Henry Snyder

3.(b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Maria Bowman Benn
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) February 5, 1860
 8. AGE: Years 86 Months 9 Days 25 If less than one day
 hrs. min.

9. Birthplace Cumberland
 (Town, county, and state)
 10. Usual occupation Retired
 11. Industry or business

MOTHER FATHER
 12. Name ?
 13. Birthplace Germany
 14. Maiden name ?
 15. Birthplace Germany

16. Informant Mrs. Pearl Sindy
 Address Cresaptown, Md.

17. Burial Date thereof December 2, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Hillcrest Cemetery
 Location Cumberland, Md.

18. Funeral director John J. Hofus
 Address Cresaptown, Md.
12/4/46 M.H. /

19. (Date reg'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1946, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19..... to 19.....
 and that I last saw him alive on 11-3- 1946

Immediate cause of death Long-time heart failure DURATION 2 months

Due to chronic myocarditis 2 years

Due to ?

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE L. Brings M.D. M. D. or other
 Address 59 Green St. Date signed 12-4-46

RECEIVED

DEC 13 1946

B READER

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

10669

40

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 80 yrs

Hospital, institution, or street address where death occurred:

570 Bedford St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 570 Bedford St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Peter Spoerl

3. (b) Social Security Number

None4. Sex Male 5. Color of race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Catherine Roeder

7. Birth date of deceased (mo., day, yr.)

July 4 1866

6.(c) If alive, give age

8. AGE:

Years 80 Months 4 Days 15 It less than one day

9. Birthplace

Cumberland, Ind.
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Garage Owner

FATHER

12. Name Ger. M. Spoerl

13. Birthplace

Germany

MOTHER

14. Maiden name Elizabeth Herpich

15. Birthplace

Germany

16. Informant

G. E. Spoerl

Address

Cumberland

17.

Burial Date thereof Nov 21, '46
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory

St. Anselm's

Location

Cumberland

18. Funeral director

Arms, Stein & Co

Address

Cumberland

19.

Nov 20 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1946 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 10 1946 to Nov 19 1946
and that I last saw him alive on Nov 19 1946

Immediate cause of death

Myocardial Failure

DURATION

Due to

Chronic Myocarditis

Due to

conformation of disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

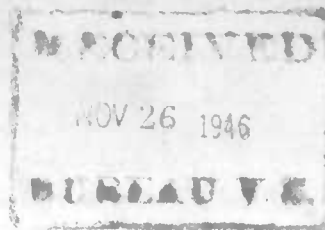
Dr. J. P. Franklin M. D. or other
Address Cumberland Date signed 11/19/46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-154

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

CERTIFICATE OF DEATH

Reg. Dist. No. 40

10670

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland, Maryland

How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Christie Road 141 Reynolds St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George ~~Stein~~ Steen

3. (b) Social Security Number

220-10-0122

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Mrs. Elizabeth ~~Stein~~ Steen

6. (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) 1/26/1868

8. AGE: Years 78 Months 5 Days 10 If less than one day
..... hrs. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name James Steen

13. Birthplace Scotland

14. Maiden name Catherine Mathias

15. Birthplace Scotland

16. Informant Theodore Stegmaier

Address Rt. 4, Cumberland, Md

17. Burial Date thereof December 5, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenmount Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hays

Address Cumberland, Md.

19. Nov 30 46 Joseph D. Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1946 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1946 to November 29, 1946
and that I last saw him alive on November 29, 1946

Immediate cause of death Miliary Tuberculosis of lung DURATION 2 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Johnson M. D. or other

Address Cumberland, Md. Date signed 11-29-46

RECEIVED
DEC 3 1946
BUREAU 78

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1600

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegheny Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegheny
 City or town Rural Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 6 (Largest Grove)
 (If rural, give LOCATION)

2. (a) If veteran, name war.

3. (a) FULL NAME

Roger Lee Stottlemeyer

3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1946

8. AGE: Years Months Days If less than one day
2 hrs. 40 min.

9. Birthplace Cumberland, Allegheny, Md.
 (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

12. Name Michael O. Stottlemeyer13. Birthplace Cresaptown, Md.14. Maiden name Delores Morris15. Birthplace Corriganville, Md.16. Informant Edna MorrisAddress Rt. 6, Cumberland, Md.

17. Burial Date thereof Nov. 27, 1946
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Porters CemeteryLocation Hyndman, Penna.18. Funeral director John J. StofferAddress Cumberland, Md.

19. Nov. 27, 46 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 19 46 at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 25 19 46 to Nov. 25 19 46and that I last saw him alive on Nov. 25 19 46Immediate cause of death Asphyxiation

DURATION

Due to Breath delivery

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE Marcello J. W. M. D. or other

Address 133 Va Ave. Date signed 11/26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

RECEIVED
DEC 3 1946
BUREAU 18

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 714

CERTIFICATE OF DEATH

Reg. Dist. No. 1007290

1. PLACE OF DEATH:

County Allegany
 City or town Fayetteville, Eckhart Mines
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 months
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegany
 City or town Fayetteville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Eckhart Mines
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clarence Rudolf Surran

3. (b) Social Security Number

215-18-8074

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Mildred Stale

7. Birth date of deceased (mo., day, yr.) July 4th, 1921
 6. (c) If alive, give age 21 years

8. AGE: Years 25 Months 4 Days 9 If less than one day
 hrs. min.

9. Birthplace Mountain View, Md
 (Town, county, and state)

10. Usual occupation Mine11. Industry or business Coal Mines12. Name George Wm. Surran13. Birthplace Fayetteville, Md14. Maiden name Eliza Sharpless15. Birthplace Fayetteville, Md16. Informant Mr. George W. SurranAddress Mountain View, Md17. Burial Date thereof 11-15-1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory AlleganyLocation Fayetteville, Md18. Funeral director Jacob W. WapnerAddress Fayetteville, Md19. 11-13 19 46 Mr. Harvey N. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 19 46 at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 19. 19.

and that I last saw him Dead 19 46Immediate cause of death A mine accidentInterpersonal hemorrhage fromDue to a crushed skullDue to A fall of roof coal in Mine No. 4Was killed instantly. Certified

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

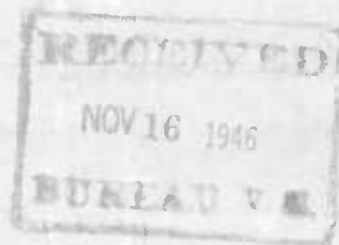
Accident, suicide, or homicide Acc Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? Yes23. SIGNATURE J. V. Downing M.D. M. D. or otherAddress Cumberland, Md Date signed 11-12-46

Deputy Medical Examiner - Allegany Co.



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 10673 40

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

533 Necessity St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Mrs. Mary E. Uhl

3.(b) Social Security Number

None

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

John H. Uhl

7. Birth date of deceased (mo., day, yr.)

May 22 1897

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

69511

hrs.

min.

9. Birthplace

Mt. Savage Ind.
(Town, county, and state)

10. Usual occupation

Homemaker

11. Industry or business

at HomeMOTHER
FATHER

12. Name

John H. Uhl

13. Birthplace

Ind.

14. Maiden name

Anna M. Folk

15. Birthplace

Ind.

16. Informant

Mrs. Rae Anna Marshwood

Address

Cumberland

17.

Burial

Date thereof

11-6-46
(month) (day) (year)

Cemetery or crematory

St. George Cem.

Location

Mt. Savage Ind.

18. Funeral director

Louis Stein Inc.

Address

Cumberland

19.

Nov 646Joe P. Franklin M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1946 at 12.15P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h er Dead Nov. 3 1946

Immediate cause of death

Coronary occlusion

DURATION

at once

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H.V. Deming M.D.

M. D. or other

Address Cumberland, Ind.Date signed 11-4-1946

Deputy Medical Examiner - Allegany Co.

NOV 13 1946

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2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10674 40

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 68 Cresap St
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Edward W. Valentine

3. (b) Social Security Number

220-10-2442

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Hattie Mae Garlitz

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) November 10, 18868. AGE: Years Months Days If less than one day
59 11 23 hrs. min.9. Birthplace Pattersons Creek, W. Va.
(Town, county, and state)10. Usual occupation Watchman11. Industry or business B & O TR12. Name Theodore Valentine13. Birthplace Allegany Co., Md.14. Maiden name Mary Elizabeth Long15. Birthplace Kentucky16. Informant Gilbert GarlitzAddress 20 So. Mechanic St.17. Burial Data thereof Nov. 6, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcrest CemeteryLocation Cumberland, Md.18. Funeral director J. P. FranklinAddress Cumberland, Md.19. Nov. 6 19 46 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 19 46 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 46 to 19 46and that I last saw him Dead Nov. 3 19 46

Immediate cause of death

Cerebral hemorrhage DURATION about 20 hrs.Due to Fracture of the skull

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 11.3.46Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, or business? B & O RR CrossingMeans of injury Auto hit him, his head hit drive wheel of B & O RR engine Injured at work? yes23. SIGNATURE H.V. Deming M.D. M. D. or otherAddress Cumberland Md Date signed 11-4-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 13 1946

BUREAU OF

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-8

CERTIFICATE OF DEATH

10675
Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegheny
 City or town Cumtberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 68 yrs
 Hospital, institution, or street address where death occurred:
142 Polk St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Cumtberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 142 Polk St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Frederick Jacob Weisenmiller

3. (b) Social Security Number

220-10-9157

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Bertha Matthews

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8 1878

8. AGE: Years 68 Months 3 Days 23 hrs. min.

9. Birthplace Cumtberland Ind.
(Town, county, and state)10. Usual occupation Machinist11. Industry or business Belmont Corp of A.12. Name Frederick Weisenmiller13. Birthplace Cumtberland Ind.14. Maiden name Mary Maty15. Birthplace Cumtberland Ind.16. Informant Mrs Bertha WeisenmillerAddress Cumtberland Ind.17. Burial Date thereof Nov 5 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St Peter & Pauls Cem.Location Cumtberland Ind.18. Funeral director Louis Stein IncAddress Cumtberland19. Nov 4 19 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 19 46 at 10:30 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 19 46 to Nov 1 19 46and that I last saw him alive on Nov 1 19 46Immediate cause of death Lympho-sarcoma ofesophagus & fundus of stomach

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D.Address Cumtberland Ind. Date signed 11/2/46

MARGIN RESERVED FOR BINDING

VS A15

9-45,15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

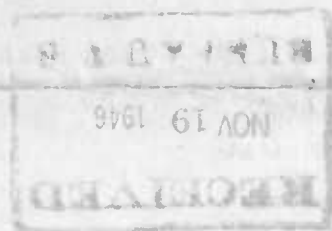
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NOV 13 1946

INDEA

2-35

2-31



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore BPO

CERTIFICATE OF DEATH

Reg. Dist. No. 10677 40

1. PLACE OF DEATH:

County Allegheny
 City or town Butterfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 86 yrs.
 Hospital, institution, or street address where death occurred:
57 S. Centre St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Butterfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 57 S. Centre St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Elizabeth Ellen Willard

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 10 1860

8. AGE: Years 86 Months 4 Days 23 If less than one day
 hrs. min.

9. Birthplace Butterfield Ind.
 (Town, county, and state)

10. Usual occupation House keeper

11. Industry or business at home

12. Name John P. Willard
 13. Birthplace B Ind.

14. Maiden name Mary Ann Reid
 15. Birthplace Butterfield Ind.

16. Informant Helene Doe Kee
 Address Butterfield Ind.

17. Burial Date thereof Nov 5 46
 (Burial, cremation, or removal) Which? (month) (day) (year)
 Cemetery or crematory Rose Hill Cem.
 Location Butterfield Ind.

18. Funeral director Louis Steiner Inc.
 Address Butterfield

19. Nov 5 46 J. P. Franklin M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 19 46, at 4:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 3 46
 and that I last saw him alive on Nov 1 46

Immediate cause of death Infectious hepatitis
Cardiac vascular
renal disease

DURATION
2 mos.
4 yrs.

Due to
 Due to
 Other conditions

(Include pregnancy within 9 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:
 Accident, suicide, or homicide
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE D. B. Jones M.D.
 Address Med. of Bldg Date signed 11-4-46

MARGIN RESERVED FOR BINDING

VS A15

9-4-5-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13 1946
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2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

10678



CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? TWO DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY
City or town CUMBERLAND Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. BOWMAN'S ADDITION Route #3
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

JAMES A. WILSON

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALEWHITEWidowed6. (b) Name of husband or wife Florence Wilson

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 21, 18818. AGE: Years Months Days If less than one day
65 6 15 hrs. min.9. Birthplace W. Va.
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Edward Wilson13. Birthplace So. Carolina14. Maiden name Emily Dixon15. Birthplace Va.16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND17. Burial Date thereof Nov. 12, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Allegany County Home Cem.Location Cumberland, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. Nov. 9, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH NOV. 6, 1946 19 at 10:00

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/1/46 19 to 11/6/46 19
and that I last saw him alive on 11/6/46 19

Immediate cause of death

DURATION

Cerebral hemorrhage

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. P. Franklin, M.D. M. D. or otherAddress Cumberland, Md. Date signed 11/7/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 13 1946
BUREAU OF

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 100-221

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH:

County allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
66 N. Water St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State md County allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 66 N. Water
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

Bertha Rephan Winner

3. (b) Social Security Number

none

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Harry Winner
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Sept 10 - 1894
 8. AGE: Years 52 Months 2 Days 12 If less than one day _____ hrs. _____ min.
 9. Birthplace Eckhart - alleg - md
 (town, county, and state)
 10. Usual occupation housewife

11. Industry or business

12. Name Freda Rephan
 13. Birthplace Eckhart, md.
 14. Maiden name Sarah Clinge
 15. Birthplace Eckhart, md.

16. Informant Mrs Robert Sweetzer
 Address Frostburg, md.

17. Burial Date thereof Nov 25-1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory allegany
 Location Frostburg, md.

18. Funeral director J. J. Oberst
 Address Frostburg, md.

19. 11-25 19. 46 md Nancy H. Roe
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 19. 46 at 3:00 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased
Sept 1 19. 46 to Nov 22 19. 46
 and that I last saw him alive on Nov 13 19. 46

Immediate cause of death Pulmonary embolism
 Due to embolism from varicose veins of legs

Due to _____
 Due to _____

Other conditions _____
 (include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE WOM Carel md
 Address Frostburg md Date signed Nov 24 1946
 M. D. or other

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NOV 27 1946

BUREAU V S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 53 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 117 GREENE ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MR. GEORGE W. WINTERS

3. (b) Social Security Number

None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6. (b) Name of husband or wife GERTRUDE LONG

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 18, 1863

8. AGE:	Years	Months	Days	It less than one day
83	2	21		hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business U.S. Post Office Dept.

12. Name W. WINTERS

13. Birthplace PENNSYLVANIA

14. Maiden name Eliza Cecil

15. Birthplace PENNSYLVANIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial Date thereof Nov. 11, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory HillCrest Burial Park

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Nov. 11, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 9, 1946, at 1:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 8, 1946, to Nov. 9, 1946.

and that I last saw him alive on Nov. 8, 1946.

Immediate cause of death Pulmonary embolism

DURATION

Immediate

Due to Amputation right leg above knee

Due to Arterio-sclerotic gangrene right lower leg

Other conditions Scurvy

(Include pregnancy within 3 months of death)

Major findings of operations Gangrene right lower extremity Date of op. Nov. 8, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Faw, Jr. M.D.
M. D. or other

Address 5 Washington St. Date signed Nov. 10, 1946

2-35

12

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NOV 19 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

90

1. PLACE OF DEATH:

County Allegany
City or town Franklin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Pa. County Allegany
City or town Franklin
(If outside city or town limits, write RURAL and give nearest town)
Street No. 216 Centre
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

Margaret Teresa Sobford

3. (b) Social Security Number

✓

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Orville C. Sobford

7. Birth date of deceased (mo., day, yr.) Oct-17-1969 6. (c) If alive, give age 36 years

8. AGE: Years 37 Months 1 Days 4 It less than one day
hrs. min.

9. Birthplace Greenfield Township, Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Jessie Baker

13. Birthplace Greenfield Township, Pa.

14. Maiden name Beatty

15. Birthplace Franklin, Pa.

16. Informant Mr. J. Sobford

Address 216 Centre St. Franklin, Pa.

17. (Burial, cremation, or removal, Which?) Burial Date thereof Nov. 15-1946
(month) (day) (year)

Cemetery or crematory St. Michael's Cemetery

Location Franklin, Pa.

18. Funeral director Joseph Baker

Address Franklin, Pa.

19. 11-23 19 46 Mr. Harvey H. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1946 at 2:08 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/30 to 11/21 19 46

and that I last saw him alive on 11/18 19 46

Immediate cause of death Carcinoma Cervix

& abdominal metastases

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma Cervix

Cropsey Date of op. July 1944

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Hilda J. Walker, M.D. M. D. or other

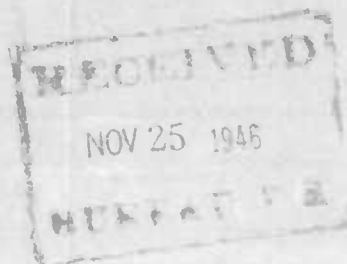
Address Franklin, Pa. Date signed 11/22/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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1-35

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County ALLEGANY CO.City or town CUMBERLAND MD.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 25 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PA. County WASHINGTONCity or town W. BROWNSVILLE, PA.
(If outside city or town limits, write RURAL and give nearest town)Street No. 11 MIDDLE ST.
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

MRS MARGARET WYSNER

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife JOSEPH WYSNER6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) JUNE 12, 1860

8. AGE:

Years

Months

Days

If less than one day

86421 hrs. min.9. Birthplace WASHINGTON MD.
(Town, county, and state)10. Usual occupation HOUSEWIFE11. Industry or business Own home

FATHER

12. Name BERNARD O'DONNELL13. Birthplace PA.

MOTHER

14. Maiden name BRIDGET GLEASON15. Birthplace IRELAND16. Informant MEMORIAL HOSPITALAddress CUMBERLAND MD.17. Burial
(Burial, cremation, or removal. Which?)Date thereof Nov. 6, 1946
(month) (day) (year)Cemetery or crematory St. Peter & Paula CemeteryLocation Cumberland, Md.18. Funeral director John J. HefnerAddress Cumberland, Md.19. Nov 5, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 3, 1946 at 10:22 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

October 9, 1946 to November 3, 1946and that I last saw him alive on November 3, 1946

Immediate cause of death

Carcinoma of
right breast.

DURATION

2 years.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

23. SIGNATURE John J. Hefner

M. D. or other

Address Cumberland, Md. Date signed 11-8-46

13 1946

BUREAU

2-35-

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

CERTIFICATE OF DEATH

10683

Reg. Diat. No. 40

1. PLACE OF DEATH:

County Allegheny
City or town Cornhusland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
47 Elder St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Cornhusland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 47 Elder St.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Mary Albrie Zahradka

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Frank Jos. Zahradka 6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) May 12, 1874
8. AGE: Years 72 Months 6 Days 1 If less than one day _____ hrs. _____ min.
9. Birthplace Prague, Bohemia
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Francis Mubrey
13. Birthplace Bohemia
14. Maiden name Unknown
15. Birthplace

16. Informant Francis M. Zahradka
Address Cornhusland

17. Burial Date thereof Nov 16, 46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Marys Cem.
Location Cornhusland
Louis Stein Inc

18. Funeral director Louis Stein Inc
Address Cornhusland

19. Nov 14 1946 J.P. Faulchi, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1946 at 11 A. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1946 to Nov 13 1946
and that I last saw him alive on Nov 1946
Immediate cause of death Coronary
or chronic
DUE TO Cardio Vascular
renal disease
DURATION 2 hrs
DUE TO 3 yrs
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE MEB Owens
Address 137 Va ave Date signed 11/14/46
M. D. or other

MARGIN RESERVED FOR BINDING

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VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 19 1966
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 140

1. PLACE OF DEATH: Allegany

County.....

City or town..... Ellerslie
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Allegany.....

City or town..... Ellerslie
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Forrest Edward Zeigler

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1906

8. AGE: Years 40 Months 10 Days 1 If less than one day hrs. min.

9. Birthplace Pittsburgh, Pa.
(Town, county, and state)
None (Invalid)

10. Usual occupation.....

11. Industry or business.....

12. Name Owen Zeigler

13. Birthplace Penna

14. Maiden name Hattie Kimmel

15. Birthplace Stoystown, Pa.

16. Informant Mrs. Mabel Krampf
Address Ellerslie, Md.17. Burial Date thereof Nov. 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory xxxxxx Stoystown
Stoystown, Pa.

Location.....

18. Funeral director Harvey H. Zeigler

Address Hyndman, Pa.

19. Nov 30 46 J. Lloyd Wolfe
(Date rec'd by registrar) 19..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1946 19..... at 11:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 27 1946

and that I last saw him alive on Nov 27 1946

Immediate cause of death.....

Bronchopneumonia

DURATION

7 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Zupper MD

M. D. or other

Address Hyndman Pa Date signed 11/29/46

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DEC 12 1946

BUREAU

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (945)

10685

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County... Allegany
City or town... Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
143 Fredrick St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Md. County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 143 Fredrick St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
William R. Zimerla
3. (b) Social Security Number
None

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced
Widower
6. (b) Name of husband or wife... Harriet (Weber) Zimerla

6. (c) If alive, give age... years
7. Birth date of deceased (mo., day, yr.) Sept. 20, 1873

8. AGE: Years Months Days If less than one day
73 I 28 hrs. min.

9. Birthplace... Cumberland, Md.
(Town, county, and state)

10. Usual occupation... Parking Lot Watchman

11. Industry or business Cumb. Parking Lot

12. Name... Geo. W. Zimerla

13. Birthplace... Md.

14. Maiden name... Lula Mundel

15. Birthplace... Md.

16. Informant... Geo. Zimerla

Address... Cumberland, Md.

17. Burial Date thereof... Nov. 20, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... Trinity Lutheran Cem.

Location... Cumberland, Md.

18. Funeral director... Louis Stein Inc.

Address... Cumberland, Md.

19. Nov. 20, 1946 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH... Nov. 18, 1946 at 6 A. about

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19... to 19...
and that I last saw him alive... Dead Nov. 18, 1946

Immediate cause of death...
Coronary sclerosis and insufficiency.

Due to... Artero-sclerosis

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

Deputy Medical Examiner... Allegany

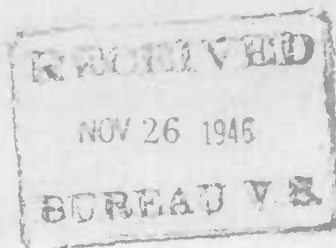
23. SIGNATURE... H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address... Cumberland, Md. Date signed 11-18-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within Corporate Limits

DR. MIRKIN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116814

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL
How long in hospital or institution? ONE DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 332 N. MECHANIC ST., CITY
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

MRS. MYRTLE ZINN

3.(b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED

6.(b) Name of husband or wife ZINN, EMANUEL E.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 19 1890

8. AGE: Years 56 Months 7 Days 20 If less than one day hrs. min.

9. Birthplace MDIAN Sandpatch, Pa.
(Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business Own home

12. Name SECHRIST, GEORGE

13. Birthplace PA.

14. Maiden name McKinnon

15. Birthplace

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MARYLAND

17. Burial Date thereof Dec 3 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Meyersdale Union Cemetery

Location Meyersdale, Pa.

18. Funeral director John J. H. H. H.

Address Cumberland, Md.

19. Nov 30 46 Joseph O. Zinn
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 30 19 46 at 7:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 to Nov 30 46

and that I last saw him alive on 29 Nov 46

Immediate cause of death Probable pulmonary embolism

Due to hypertensive & arterio-sclerotic heart dis.

Due to arteriosclerosis

Other conditions 1) nephrosclerosis 2) months edema 3) Gangrene left leg 3 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Mirkin M.D.

Address 1155 Centre St.

Date signed 11/30/46

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DEC 3 1946

BUREAU

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